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JANUARY 1989

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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HIGHLIGHTS 1989**



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THE COVER

Photo by Chuck Rogers, of Atlanta.

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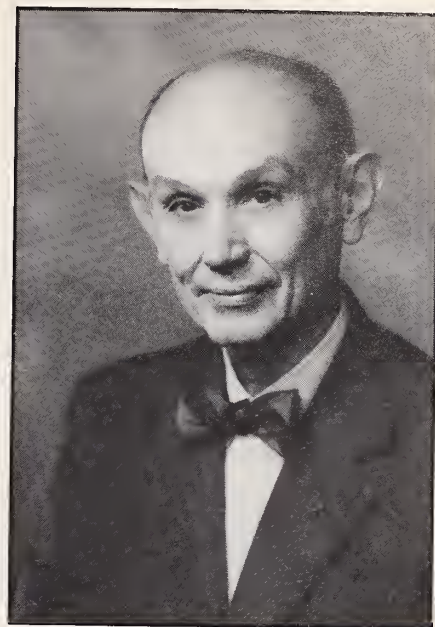
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*Joseph P. Bailey, Jr., M.D.*

## *RBRVS — A Promise or a Threat?*

**T**HE DEVELOPMENT OF THE REIMBURSEMENT for physician effort in patient care is a fundamental part of the practice of medicine and has been regulated in this country to a great degree by advent of the Medicare program. This program began amidst protests and predictions of tremendous future difficulty which have occurred. As to the consideration for the cost of medical care, the most recent proposal is the developing Resource-Based Relative Value Scale (RBRVS) study. This study would alter the payment for care by the reallocation of funds — decreasing procedural compensation and increasing payments for non-procedural activities. This proposal is generating strong support from the internal medicine, family practice, and pediatric areas while meeting opposition from many procedurally-oriented specialties. This issue could divide the House of Medicine

because of economic factors unless we do something about it.

The Physician Payment Review Commission (PPRC) is also considering volume control and regional caps on fees. These efforts are clearly directed at cost control and again take little into consideration about expanding numbers of patients, the need for more care, and the desires of the American people. As never before, the character of our consideration of these issues is fundamental to the ultimate state of medical practice in both the immediate and distant future. If two camps develop producing a clear split in organized medicine, we can be certain that the government will further take advantage of our vulnerability.

I plead with every physician to carefully examine the issues at hand and take a position that fairly addresses fees and reimbursement programs while not allowing outside forces to dominate our profession.

*Joseph P. Bailey, Jr.*

## NEW MEMBERS

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Wright, Barry E., Ophthalmology  
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(Active) 4750 Waters Ave., Ste.  
310, Savannah, 31404

## PERSONALS

### Baldwin CMS

Milledgeville physician, **Samuel M. Goodrich, M.D.**, was elected vice chairman of the Georgia Section of The American College of Obstetricians and Gynecologists (ACOG) for a 3-year term beginning November, 1988. Dr. Goodrich has practiced in Milledgeville since 1969 and is affiliated with Baldwin County Hospital. He has been a member of the State Task Force on Hospital Maternity and Newborn Facilities, chairman of the Subcommittee on Hospital Maternity Standards for



Regionalization of Maternity Services, a member of MAG's Committee on Maternal and Infant Health, and former president of the Georgia State Obstetrical and Gynecological Society. He has been chairman of the ACOG Georgia Section for the past 3 years.

## Cobb CMS

**Robert O. Stephens, M.D.**, of Marietta, was appointed to the position of Kennestone System Vice President for Medical Affairs. Dr. Stephens is a board-certified pediatrician and has been on staff at Kennestone since 1970. He was chief of pediatrics in 1981 and president of the medical staff in 1983. His responsibilities in this new position will include work with the hospital authority, medical staffs, and administrative officers in such areas as medical education, quality assurance, communications, planning as well as other medical staff activities.

## DeKalb CMS

**G. Douglas Talbott, M.D.**, was awarded the American Medical Association's Distinguished Service Award at the 1988 AMA Impaired Health Conference held last October 27-30. This award is the first of its kind to be presented by the AMA.

Dr. Talbott is Administrator of Talbott Recovery System in Atlanta. He holds a faculty position as Clinical Professor in the Emory University School of Medicine's Department of Psychiatry, teaching about alcoholism and drug addiction to medical students, and is President of the American Academy of Addictionology.

He was also recently awarded the AMA's Education and Research Foundation's Award in recognition of his outstanding achievement in the treatment and education of chemical dependence.

## Medical Association of Atlanta

**Joseph A. Wilber, M.D.**, of Atlanta, medical director of the Georgia Division of Public Health's AIDS project, has been named secretary of the board of Jerusalem House, an interfaith project to establish metro Atlanta's first residential care center for homeless people with AIDS. Jerusalem House is actively seeking many sources of both volunteer and financial support.

## Richmond CMS

**John W. Richards, Jr., M.D.**, associate professor of family medicine at the Medical College of Georgia, received the U.S. Surgeon General's medallion for his work with Doctors Ought to Care (DOC), a group of doctors that distributes information about smoking and drinking to young adults. Dr. Richards, the national president of DOC, received the award from U.S. Surgeon General C. Everett Koop at the annual American Academy of Family Physicians' meeting in New Orleans last October.

## Troup CMS

**Robert Copeland, M.D.**, a cardiologist from LaGrange, recently became the first physician in that region to be



*Atlantans come together to help establish the first residential care center for homeless people with AIDS in the Metro Atlanta area. Serving as president of the board of this interfaith project, called Jerusalem House, is Evelyn Ullman; Joseph A. Wilber, M.D., (R) is secretary of the board. Pictured between them is Michael Lomax, Fulton County Commissioner.*

awarded certification as a Diplomate in Geriatric Medicine by the American Board of Internal Medicine.

## DEATHS

**Francis Marion Gay, M.D.**, aged 73, of Moultrie, died last October following a brief illness.

Dr. Gay, received his medical degree from Emory University School of Medicine. He completed his internship and residency at Baroness Erlangear in Chattanooga, Tenn., and practiced family medicine for 48 years.

**Teofredo C. Aranas, M.D.**, died last November in an automobile accident at the age of 39. Dr. Aranas was born in Carcar, Phillipines, and had lived in Columbus since 1979. He practiced with Radiology Associates of Columbus.

## AWARDS

### Prison Health Project Receives Award

MAG's Program on Prison Health Care received a special award from the National Commission on Correctional Health Care. Mr. Bernard Harrison, President of the Commission, expressed his thanks for the participation of MAG in the program to improve medical care in the nation's prisons, jails, and juvenile confinement facilities. He stated, "From the outset, when the program was housed at the American Medical Association, the participation of state medical societies has been its most important asset. MAG's continued support and the expert assistance of Dorothy Parker and her colleagues, the MAG Committee on Prison Health Care, has had such a positive impact on correctional health care that it is often cited by the courts and by state and local legislative bodies."

The award was presented at the 12th Annual Conference on Correctional Health Care on November 2 in Orlando, Florida. Dorothy J. Parker, MAG staff, and Floyd Bliven, Jr., M.D., and Charles A. Meyer, Jr., M.D., both members of the MAG Prison Health Committee, received the plaque for MAG. The plaque recognized MAG "for its concern that incarcerated adults and juveniles receive adequate medical care and its participation in the nationwide accreditation program for prisons, jails, and juvenile facilities."

### Journal Receives Award

The *Journal of the Medical Association of Georgia* won a Silver Flame Award (2nd Place) in a competition sponsored by the Atlanta Chapter of the International Association of Business Communicators. The award was given for the excellence of the cover photograph of the Proceedings Issue (June 1988) and was presented to Susan J. Dillon, Managing Editor, at the 1988 Golden Flame Awards Program last November. Other contestants included AT&T, Southern Bell, C&S, Cox Communications, the Coca-Cola Company, Mead Packaging, and Georgia-Pacific Corp., to name just a few.

The photo, taken by Atlanta photographer Chuck Rogers, was of the Waving Girl at dawn on the Savannah River. Remember? If not, call the *Journal* office, and we'll be happy to send you a copy.



National Rural Health Association  
12th Annual National Conference  
April 30-May 3, 1989  
Reno, Nevada



# Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) from July through September, 1988.

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category 1 credit by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Anderson, Walter Faust, *Atlanta*  
Arnold, Thomas Seymour, *Augusta*

Boger, Robert Martin, *Atlanta*  
Boyd, Donald Lee, *Albany*  
Brannen, Alfred L., *Augusta*  
Brende, Joel Osler, *Columbus*  
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Brunt, Gwynne Taylor, *Atlanta*  
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Burnside, Edward H., *Calhoun*  
Byrd, Marcia Virginia, *Roswell*  
Delgado, Jose Arturo, *Milledgeville*

Dickens, Martha Delle, *Waycross*  
Dunn, Byron Harrison, *Conyers*  
Engel, Nancy Lou, *Atlanta*  
Fehlenberg, Richard Daniel, *Macon*

Fermanis, Ernest George, *Atlanta*  
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Finkelman, David, *Lithia Springs*  
Floore, Stephen Lawrence, *Cairo*  
Funk, Mark Raphael, *Columbus*  
Gardner, Stephanie Stein, *Atlanta*  
Goldman, Norman Isaac, *Columbus*

Grant, Frances Barnes, *Montezuma*

Grant, Ralph Peery, *Atlanta*  
Green, Charles G., *Augusta*  
Hanzlick, Randy Lee, *Atlanta*  
Krauss, Jonathan Seth, *Augusta*  
Kurzbach, Elmar, *Savannah*

Lopez-Sotomayor, Manuel A, *Atlanta*

Mason, James Lee, *Atlanta*  
May, William Edward, *Macon*  
McFadden, Isaac Joseph, *Marietta*  
McRoberts, Martin Lanier, *Albany*  
Mirra, Suzanne Samuels, *Decatur*  
Nielson, Craig Morgan, *Albany*  
Nolen, John Henry, *Marietta*  
Ordonez, Carlos, *Dunwoody*  
Perlow, Joan Stevens, *Marietta*  
Pickens, Frank Major, *Atlanta*  
Potitong, Banlu, *Thomaston*  
Quayle, James Michael, *Roswell*  
Reasoner, John P., *Martinez*  
Richards, John Corliss, *Fort Benning*

Richmond, John Dwight, *Dalton*  
Roof, Jonathan Buist, *Blue Ridge*  
Sacks, Linda Mann, *Savannah*  
Sampson, John Francis, *Atlanta*  
Scoggins, Ted A., *LaFayette*  
Shearin, William A., *Conyers*  
Smith, Gregory Eschol, *Augusta*  
Stancil, Melody Ann, *LaGrange*  
Star, Franklin Julian, *Columbus*  
Sung, Yung-Fong, *Atlanta*  
Tilson, Paul Junior, *Statesboro*  
Tobias, Hal M., *Marietta*  
Tutsch, Wilbert Rudlof, *East Point*  
Vohman, M. Darius, *Atlanta*  
Willers, Donald Roger, *Gainesville*  
Wills, Benjamin Charles, *Savannah*

Zoret, George David, *Brunswick*

# DEBATE, DECISIONS, AND DELEGATES

## The Ayes Have It!!

If you want to be an effective leader or a fully participating member of any organization, you need to know the "Rules of the Game" that apply during business meetings. To test your procedural savvy, answer true or false to the following questions. The answers are below.

1. A president must vote to break a tie.
2. When handling business only one motion at a time may be pending.
3. A vote requiring 2/3 to pass must be counted.
4. An ex-officio member of a committee does not have a vote.
5. A motion passed by general consent means everyone is in favor of it.
6. A person can withdraw his motion at any time.

Answers — all of the statements are false. If you missed more than two, or if you want to increase your knowledge of parliamentary law, you can sign up for the workshop, Debate, Decisions, and Delegates, sponsored by PEACHTREE PARLIAMENTARIANS, at MAG's Leadership Conference this month. Call 404-428-3832 or 404-435-4635.

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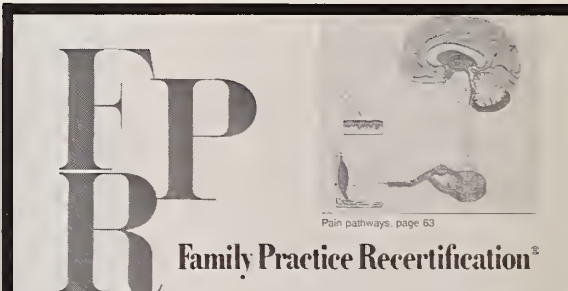
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**SPECIAL FEATURE**

Willingway: A Fellowship in Alcoholism and Drug Addiction



# MAG's 5th Annual Leadership Conference: Legislation and Medicine

January 28-29, 1989  
Waverly Hotel  
Atlanta

**E**ACH YEAR, for all our members — and especially for those Georgia physicians holding positions of leadership in MAG, their county medical societies, specialty societies or hospitals — the Medical Association of Georgia sponsors its Leadership Conference, our major update on all the late-breaking trends in medical legislation and socioeconomics.

This year the focus is exclusively on legislation, at both the state and federal levels. "LEGISLATION AND MEDICINE" will be held January 28-29 at Stouffer's Waverly Hotel in northwest Atlanta.

Highlights of our Conference Program are presented here, along with your Leadership Conference registration form. If you haven't registered yet, we invite you to examine our program and join us at the meeting for Georgia physicians' most comprehensive update on the legislative issues facing medicine.

## **Leadership Conference Highlights Saturday, January 28**

He is known simply as "The Speaker," the redoubtable Thomas B. Murphy, of Bremen. His significant influence is felt on

every piece of legislation in the General Assembly, especially on such medical issues as tort reform. This is the first time MAG has had Speaker Murphy address one of its major meetings.

This 1989 session of the General Assembly, of course, will have a number of highly-charged medical issues before it — tort reform, multiple copy prescription, mandatory continuing medical education, dispensing, nurse reimbursement, and the attempts by non-physician health care providers to expand their scopes of practice. We've blocked these topics on Saturday morning, and invited the most knowledgeable and influential state legislators to address them: Senators Pierre Howard of Decatur and Nathan Deal of Gainesville, State Representatives Tommy Chambliss of Albany, and Buddy Childers of Rome.

Lunch is on your own, except for "young physicians." Those MAG members who meet the criteria of the MAG Young Physicians Section (under 40 years of age, or in their first 5 years of practice) are invited to hear State Representative Jim Pannell of Savannah in a special YPS luncheon. We gratefully acknowledge the support of Ethicon, Inc., for this event.

**I**n the afternoon we turn our attention to the national scene. The Honorable Wyche Fowler of Atlanta, Georgia's junior United States Senator, will offer his views on "The Meaning of the Recent Presidential Election." Then Congressman Ed Jenkins, who represents Georgia's 9th District in the U.S. House of Representatives, will speak on issues of physician regulation in the Congress. Representative Jenkins sits on the powerful House Ways & Means Committee.

Later in the afternoon, from his perspective as a staff director of the AMA's Washington lobby, Jim Drake will forecast medical legislation and socioeconomics under the new Congress and the Bush Administration.

**O**ne of the hottest medical issues of 1989 will be the Resource-Based Relative Value Study, and the methods whereby the Physician Payment Review Commission in Washington, D.C., will seek to change comparative levels of various physicians' reimbursement. None other than the President-Elect of the American Medical Association, Alan R. Nelson, M.D., who's been right on top of the issue, will offer the latest developments on the RBRVS and PPRC report, due out this March.

Because comparative reimbursements for cognitive and procedural services are under intense scrutiny in the RBRVS, we will conclude the afternoon session with formal responses by James K. Van Buren, M.D., President of Georgia Society of Internal Medicine, and Eugene D. Davidson, M.D., President of the Georgia Chapter, American College of Surgeons.

Our Saturday sessions will end at 5:15. Immediately following, we invite all Leadership Conference attendees and their guests to a reception.

### Registration

To register for the 1989 MAG Leadership Conference and optional Parliamentary Procedure Workshop, please complete the registration form inserted in this *Journal*, detach it from the hotel reservation form, and mail it with your registration fee to the MAG office.

### Hotel Accommodations

The MAG has secured an attractive guestroom rate at the Stouffer Waverly Hotel, site of our previous Leadership Conferences. The rate for both singles and doubles is \$85. To make your reservations, complete the detachable lower portion of our Leadership Conference registration form and mail it directly to the Hotel. The cut-off date for MAG reservations was January 6, 1989; but rooms may still be available.

### Sunday, January 29 Optional Workshop

#### "Debate, Decisions and Delegates"

#### A 3-Hour Seminar in Basic Parliamentary Procedure Designed Especially for Physicians 9 A.M. - 12 Noon

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To help you learn the "rules of the game" applying to business meetings, the MAG is offering "Debate, Decisions and Delegates." Our faculty will be Mary Lou Stephens, PRP, and Julia von Haam, PRP. Both are Professional Registered Parliamentarians, and are married to physicians practicing in Atlanta. They have prepared materials specifically for physicians to teach you the procedural skills you need for . . .  
 . . . debate: controlling discussion/rules of debate  
 . . . decisions, determining consensus, expediting business/motions to accomplish your business  
 . . . delegates: being an effective representative/serving in the MAG House of Delegates and on Reference Committees.

### "LEGISLATION AND MEDICINE"

Saturday, January 28

	<i>MAG Member</i>	<i>Non-Member</i>
Physician	\$75	\$175
Resident Physician	\$25	\$40
Auxiliary/Spouse	\$25	\$40

### "DEBATES, DECISIONS, AND DELEGATES"

Sunday, January 29

Physician	\$40
Auxiliary	\$35



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# LETTERS

Dear Editor,

I was quite pleased to see the November issue devoted to my specialty of psychiatry. The introduction by Dr. Underwood, himself a surgeon, was warm and insightful. The articles by and large managed to capture the essence of the frontiers of our specialty.

However, Dr. Lewis' "Adolescent Substance Abuse," while on target, failed to mention the most common addictive disease of adolescence, tobacco addiction. This is not too surprising, as I have noted elsewhere (*Southern Medical Journal*, September, 1988, 1083-88, "Tobacco Addiction as a Psychiatric Disease"). The reasons for this neglect are many, including the fact that Sigmund Freud himself was an incurable tobacco addict and that mental health professionals have a much higher incidence of tobacco addiction than general health professionals. If we focus on a particular "bad" drug and ignore such things as tobacco, the most addicting drug known to mankind, we allow patients to fall into the myth that it is simply the particular substance they have chosen and not themselves which is the problem. We should remember that Shakespeare pointed out that the faults lie not within the stars but within ourselves.

The long-term outlook is good. Increasing numbers of psychiatrists and other mental health professionals are seriously delving into tobacco addiction and the ways of preventing and treating it. Psychiatric hospital wards from Oregon to New York,

private and governmental, have discovered that they can emulate general medical facilities and become tobacco-free. In Atlanta, most psychiatric facilities are following the lead of general hospitals in developing tobacco-free facilities. MAG's brochure, "Freedom from Addiction," gives prominent attention to tobacco, in fact, more than any other single drug of dependency!

Again, kudos to Dr. Lewis and the other contributors.

Sincerely,  
*Sheldon B. Cohen, M.D., Atlanta*

Dear Editor,

Enclosed is a copy of a letter I have recently written to Dr. Joseph P. Bailey, Jr., President, Medical Association of Georgia. It states my personal feelings with regard to the State of Georgia's Informed Consent Law. I have a feeling that my sentiments are shared by many of my colleagues, particularly other Radiologists, Urologists, and Neurologists who deal with intravenous contrast. I would like very much to see this letter appear in "Letters to the Editor."

Thank you very much for your consideration.

Sincerely,  
*Charles W. Brown, M.D.*  
*Diagnostic Radiologist, Jesup*

Dear Dr. Bailey,

I have very recently attended one of the Medical Association of Georgia/MAG Mutual Insurance Company's seminars designed to help the practicing physician deal with the State of Georgia's new informed consent law of which

the Medical Association of Georgia is so unjustly (I feel) proud. First, let me state that I do not believe that any ethical practitioner of Medicine in this country is against the principle of Informed Consent. I certainly am in favor of the patient's right to Informed Consent. However, the extension of Informed Consent to the intravenous injection of contrast material was grossly unnecessary. For this, I would like to express my deep disappointment and frustration with MAG.

The interests of all physicians who deal with intravenous contrast have not been served by either the Medical Association of Georgia or the Legislature of the State of Georgia. As far as the patient is concerned, the risk of a severe reaction to I.V. contrast is .025%. Researchers believe that heightened anxiety increases both the number and severity of reactions. Being informed, prior to a contrast injection for a simple I.V.P. or enhanced CT; that the procedure could cause paralysis, paraplegia, brain damage, cardiac arrest, or death will certainly do nothing to alleviate the patient's anxiety and will, I predict, lead to more frequent and more severe reactions.

As a physician who must perform the I.V. injections 15-20 times per day, I am most frustrated and angered by the fact that the Medical Association of Georgia allowed such a law to be passed by a Legislature so poorly informed that they were obviously not cognizant of the difference between surgical procedures performed under general, spinal,

and major regional anesthesia, and diagnostic procedures involving I.V. contrast. Sadly, MAG has allowed the trial lawyers to successfully conclude another round of legislative doctor bashing. Furthermore, the MAG/MAG Mutual Seminars appear to be only an effort to "sugar coat" the problem, rather than an honest effort to deal with it.

The Medical Association of Georgia has, I believe, failed a significant segment of its membership, not to mention a large group of patients. The MAG owes both an explanation and a pledge to actively seek amendment of the Informed Consent Law. Dr. Bailey, in your own words, "We are all dedicated to our patient's needs while simultaneously having to guard against further erosion of our position to have the wherewithal to meet these needs and those of our families." (*President's Page*, October 1988). I agree that "Now is the time to plan for participation in the 1989 Legislative Session for the State of Georgia." Amendment of the Informed Consent Law should be the leading issue.

Sincerely,  
Charles W. Brown, M.D.

*EDITORIAL COMMENT:* We appreciate Dr. Brown sharing his thoughts concerning the soon-to-be-instituted "Informed Consent Law." It should be noted that such a "Law" has been proposed in the Georgia General Assembly over the past several years. When Senator Tollison died a little over

a year ago, it became clear that such a "Law" would indeed be passed during the 1988 Session of the Georgia General Assembly. The bill originally introduced by the Georgia Trial Lawyers Association was an onerous one for both patient and physician, with the potential of significantly escalating the liability insurance crisis. We were then faced with the choice of either accepting passage of such legislation or proceeding to involve ourselves with the design of a bill that could be viewed as most effectively and honestly producing significant "Informed Consent." The concept of "Informed Consent," as stated by Dr. Brown, has always been supported by the MAG and is indeed incorporated into the Code of Ethics of the AMA. The final legislation which passed the Georgia General Assembly in 1988, and which will be instituted Jan. 1, 1989, is the result of an inordinate amount of labor and cooperation between representatives of MAG and other interested parties. It is arguably the best such bill that could have been produced. It will provide an environment in which genuine "Informed Consent" of the patient can be developed and at the same time provides a mechanism whereby a physician can be best protected against frivolous and unreasonable litigation. The MAG did indeed help develop the final version of that bill, did support its passage in the final form in the Georgia General Assembly, but does not agree with every minute detail of the bill.



## *Of Endings and Beginnings*

*"The rapture of pursuing is the prize the vanquished gain."*

ANON.

ONE STANDS at the gate of the year, of a new and as yet unspoiled year, looking ahead with anticipation to fresh beginnings. Resolutions of years past, worn and faded now, pose no threat to striding again with careful disregard into an unknown future.

The practice of medicine has always been possessed, characterized, by that same aura of unpredictability. We practitioners of medicine, be we investigators, teachers, or the providers of medical care to the ill, find ourselves facing each year, and yes, each day, in that exhilarating state of knowing not what the hours ahead hold for us. Perhaps the answer to some long pursued but unsolved investigative problem. Perhaps a one-time student rising to heights of professional success. Perhaps a new and fascinating clinical case or the final successful termination of a treatment plan.

The happy, the comforting, the ego salving moments lie ahead surely, but alongside them lie menacingly the failures. The experimental and investigative

efforts gone awry. The long-sought answers yet elusive. The endless hours in patient care gone to nothing as a life ebbs away. Where the energy, the determination to continue in the face of failure? Where the youthful enthusiasm to rush forward into an unpredictable new year?

Why, right there, of course, in the unpredictability. Comforting self confidence and happy success from effort come not only after, nor are associated only with, predictability and successful outcome. They dwell, too, in failure. The philosopher spoke well who saw the "rapture of pursuing as the prize the vanquished gain."

It is so that we come again to the end of one year and the beginning of another. It is, however, but a mark on the calendar signifying little else than a point in time. Little else than a vantage point from which to anticipate the uncertainty, the exhilarating unpredictability of what lies ahead. The ancient Catalian poet knew this well when he told us,

*"Whatever end man aims for is not the final end, for that gives not true happiness. What was an end becomes a new beginning according to the course that man can understand."*

CRU

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That type of opportunity exists today in an area that is likely to be as volatile as the malpractice area has been. I am referring to nonguaranteed life and disability plans.

The spectre of AIDS is casting a long shadow in the insurance community. Because of actual claims and expected claims, most nonguaranteed plans, and plans offered by companies that are not rock solid, will be severely affected. Unless you are positioned properly, you will see a doubling and tripling of your insurance rates,

and many plans will be cancelled altogether.

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40-49	\$ 93.00	\$260.00	40-44	\$ 49.00	\$127.00
			45-49	\$ 59.00	\$142.00
50-59	\$148.00	\$370.00	50-54	\$ 70.00	\$155.00
			55-59	\$ 84.00	\$169.00
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## *A Perspective on Alternative Delivery Systems*

*Donald H. Campbell, M.D.*

**‘What we will see in the next couple of years is not the end of the HMO but the consolidation of HMOs into a few well organized and efficient agencies.’**

**A**LTHOUGH WE ARE ENCOURAGED by patients who tell us that they are leaving their HMO to opt for a more traditional form of insurance, overall HMO enrollment in Georgia has not declined. The top three HMOs in Georgia increased their enrollments in 1987. The newest developments seem to relate to the industry itself. There is a real question about whether the whole concept is financially sound. The largest HMO in the country, Maxicare, was recently forced to sell several of its plans, Atlanta included, because they could no longer pay the interest on the debt used to expand their operations. Those plans that seem to be profitable do so by controlling costs. The secret to controlling costs is limiting access to care. Access is limited geographically by a limited number of service centers. Access is also limited by a careful triage of patients by non-physician professionals who provide substantial amounts of care. Our own AMA has defined “quality care” as that care delivered according to established scientific principles most likely to produce

a favorable outcome and to keep the patient happy. Notice that the phrase “by a physician” is not to be found in the definition. Notice that the emphasis is on favorable outcome not favorable income.

What we will see in the next couple of years is not the end of the HMO but the consolidation of HMOs into a few well organized and efficient agencies. Although the shakeout in the HMO industry is inevitable in light of the astronomical losses in some plans, the earthquake causing this shakeout may have more serious implications for all of us. Most Atlanta area companies saw their health care costs rise 18-24% last year, despite low overall inflation. Companies that added utilization review programs and other cost saving strategies in the early 1980s saw several years of fairly controlled though increasing

**‘There are agencies now contracted with local employers that will provide information to patients comparing costs between treatment centers and between treating physicians.’**

Dr. Campbell practices surgery and is Chairman of Cobb County's Committee on Alternative Delivery Systems. Send reprint requests to him at 1001 Thornton Rd., Ste. 208, Lithia Springs, GA 30057.

costs. Then came 1987. The programs developed by employers in the future will be structured on even tighter controls of utilization. Employees will still have options, though these options will cost them. Employers will become more active in employee education. They will intervene whenever a costly hospitalization or procedure is planned and try to limit the cost. There are agencies now contracted with local employers that will provide information to patients comparing costs between treatment centers and between treating physicians. Programs similar to the current Southern Bell PPO will become more commonplace. We can hope that when physicians evaluate the "deals" that will be headed their way from these

various agencies that they will be cognizant of the liabilities and responsibilities associated with "contract medicine."

**A**lthough this sounds like a futile situation, there are things that you can do to protect yourself and your practice. There is no end to the ill will that you will engender if a patient discovers after the fact that the care you provided could have been gotten elsewhere for less money, unless he is ecstatic about the care you provided. We can protect ourselves by making very clear to our patients in advance of costly treatments exactly what our payment policies are. Make them aware that most often they are responsible for their bills. Write your policies

down. Have your attorney review what you have written to make sure you are saying what you want to say. Have your office manager give this information to your patients. The patient should see your manager as the one who is interested in income. You should be interested in outcome. If we expect the fee-for-service system to survive, we will need to market the advantages of that system to our patients. The health care planners have learned that health care is a local event. There is nothing more local than the relationship you have with each of your patients. Make them feel like they have received their money's worth, and they are liable to come back to you with their wallets rather than their HMO card.

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**Bone and Joint Infections** caused by *Enterobacter cloacae*, *Serratia marcescens*, and *Pseudomonas aeruginosa*.

**Urinary Tract Infections** caused by *Escherichia coli*, *Klebsiella pneumoniae*, *Enterobacter cloacae*, *Serratia marcescens*, *Proteus mirabilis*, *Providencia rettgeri*, *Morganella morganii*, *Citrobacter diversus*, *Citrobacter freundii*, *Pseudomonas aeruginosa*, *Staphylococcus epidermidis*, and *Streptococcus faecalis*.

**Infectious Diarrhea** caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni*, *Shigella flexneri*,<sup>\*</sup> and *Shigella sonnei*,<sup>\*</sup> when antibacterial therapy is indicated.

<sup>\*</sup>Efficacy for this organism in this organ system was studied in fewer than 10 infections.

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro<sup>®</sup> may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

### CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

### WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

### PRECAUTIONS

**General:** As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Quinolones may also cause anaphylactic reactions and cardiovascular collapse. Anaphylactic reactions may require epinephrine and other emergency measures.

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

**Drug Interactions:** Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

**Information for Patients:** Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
  - E. coli* DNA Repair Assay (Negative)
  - Mouse Lymphoma Cell Forward Mutation Assay (Positive)
  - Chinese Hamster V<sub>79</sub> Cell HGPRT Test (Negative)
  - Syrian Hamster Embryo Cell Transformation Assay (Negative)
  - Saccharomyces cerevisiae* Point Mutation Assay (Negative)
  - Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
  - Rat Hepatocyte DNA Repair Assay (Positive)
- Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:
- Rat Hepatocyte DNA Repair Assay
  - Micronucleus Test (Mice)
  - Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

**Pregnancy—Pregnancy Category C:** Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

## CONVENIENT B.I.D. DOSAGE

### Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg q12h
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg q12h
Urinary Tract*	Mild/Moderate	250 mg q12h
	Severe/Complicated	500 mg q12h
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg q12h

**Nursing Mothers:** It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

### ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

**GASTROINTESTINAL** (See above), painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

**CENTRAL NERVOUS SYSTEM:** (See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.

**SKIN/HYPERSENSITIVITY:** (See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands, cutaneous candidiasis, hyperpigmentation, erythema nodosum.

Allergic reactions ranging from urticaria to anaphylactic reactions have been reported.

**SPECIAL SENSES:** blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.

**MUSCULOSKELETAL:** joint or back pain, joint stiffness, achiness, neck or chest pain, flare-up of gout.

**RENAL/UROGENITAL:** interstitial nephritis, renal failure, polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

**CARDIOVASCULAR:** palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

**RESPIRATORY:** epistaxis, laryngeal or pulmonary edema, hiccup, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

**Adverse Laboratory Changes:** Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic—Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematologic—eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal—Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gamma-glutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

### OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

### DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

### HOW SUPPLIED

Cipro<sup>®</sup> (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

**\*Due to susceptible strains of indicated pathogens.  
See indicated organisms in Prescribing Information.**

For further information, contact the Miles Information Service:  
1-800-642-4776. (In VA, call collect: 703-391-7888.)

## COMMITTED TO THERAPEUTIC EFFICIENCY





# Quiet Thoughts

*From Bynum's Scrap Book . . .*

## **If We Had The Time**

If I had the time to find a place  
And sit me down full face to face  
    With my better self, that can now show  
    In my daily life that rushes so;  
It might be then I would see my soul  
Was stumbling toward the shining goal,  
    I might be nerved by the thought sublime —  
    If I had the time!  
If I had the time to let my heart  
Speak out and take in my life apart,  
    To look about and stretch a hand  
    To a comrade quartered in no-luck land;  
Ah, God! If I might just sit still,  
And hear the note of the whippoorwill,  
    I think that my wish with God's would rhyme —  
    If I had the time!  
If I had the time to learn from you  
How much comfort my word could do;  
    And I told you then of my sudden will  
    To kiss your feet when I did you ill;  
If the tears aback of the coldness feigned  
Could flow, the wrong be quite explained —  
    Brothers, the souls of us all would chime,  
    If we had the time!

RICHARD BURTON.

*We invite contributions to this Department. Please send them c/o the Journal,  
938 Peachtree St., Atlanta 30309.*

It is the light of the laser. And the miracle it is performing in the medical world. At DeKalb General, this remarkable tool has taken the form of Laser Lithotripsy, an alternative to percutaneous or transurethral lithotripsy procedures to fragment stones in the middle and upper ureter. The major advantage to the procedure is the reduced risk of damage to the ureteral wall. The procedure itself delivers a pulsating laser beam through a microscopic, flexible fiber directly to the stone. It can be viewed through a miniaturized scope. Often, it can be

## DEKALB GENERAL HAS SEEN THE LIGHT.

administered on an outpatient basis. Laser lithotripsy may be utilized on most stones in any part of the urinary tract. Or it may be used to complement what will be another new addition at DeKalb General in June, Extra-Corporeal Shock Wave Lithotripsy (ESWL), which uses externally generated shock waves on the stone

to fragment it. Shock wave lithotripsy, significantly more costly than laser, is best limited to stones occurring in the kidney or upper third of the urinary tract. With the emphasis on outpatient, DeKalb General offers the CO<sub>2</sub> Laser Surgery, which seals lymphatics and nerve endings as it cuts, reducing post-operative edema, pain, bleeding, and surgical time. At DeKalb General, CO<sub>2</sub> procedures are used mainly for GYN, urology and general surgery. On a more general basis, the procedure is used for breast resections, tumor excisions, debridement, endometriosis, pelvic adhesions and genital wart virus. A new process using the CO<sub>2</sub> Laser is operative laparoscopy, which allows surgeons to perform complex intrapelvic procedures through a scope, without requiring a large incision. The YAG Laser is used by urologists for bladder tumors; by gynecologists for endometrial ablation; and by gastroenterologists for obstructive lesions, polyps or strictures of the GI tract. DeKalb General's Magnetic Resonance Imaging (MRI) will become available later this year in the new Diagnostic Imaging Center. MRI represents a significant step forward in diagnostic imaging. Its capability for the central nervous system goes well beyond CT imaging for the head and spine. An advantage over CT is that MRI does not utilize ionizing radiation. The technology is constantly improving: cardiac imaging and evaluation of joint spaces and abdominal soft tissue are now clinically applicable.



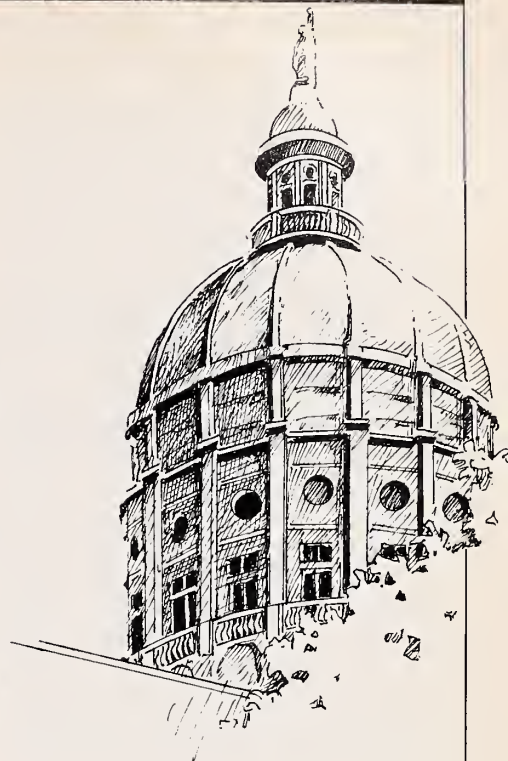
DE KALB GENERAL HOSPITAL

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# Political Involvement: The Key to Doctor-Friendly Legislation

Paul Shanor



**D**URING THE NEXT 11 YEARS, the day-to-day and patient-to-patient practice of a physician will *not* be determined by what is taught in medical school, what is learned in residency, or what is published in medical journals (even this one). Nor will it be based on a physician's individual knowledge or ability. No, the practice of medicine in the year 2000 will be decided by the votes cast in the Capitol buildings in Atlanta and Washington, D.C. The proposed laws either passed or defeated will regulate or dictate prescription patterns, patient mix, hours of training, method of payment (or non-payment), and type of competition.

Other health professions have realized for the last 10 years that political involvement brings practice expansion, legislated respect, increased income, and more freedom

of practice — all without the necessity of increased education. If individual physicians would spend just a little time meeting and educating legislators on issues that affect the health of their constituents, then medicine would face a bright future. Many legislators, particularly rural ones, have said that while MAG is right on the issues, we are not right on the politics. This is changing. During the upcoming Legislative Session, make a personal commitment to look at the issues that face your practice, and then let your legislator know how you feel about them as well as how they impact on his or her constituents. Some of the important state legislative issues that will face medicine in 1989 are:

## Multiple-Copy Script

The Attorney General, the Georgia Bureau of Investigation, and the Drug Enforcement Agency are seeking to require the use of multiple copy prescription pads in order to reduce the illegitimate use of pre-

scription drugs. They want to require the pharmacists to send one copy of each prescription to a state agency, which would put all the information on computer and constantly monitor the prescribing and use of drugs.

MAG feels that this constant monitoring is an intrusion into the physician's practice and an inva-

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**Your future medical practice will not be determined by what you've learned in medical school, residency, internship, or medical journals but rather by the votes cast in the Capitol buildings in Atlanta and Washington, D.C.**

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Mr. Shanor is MAG's Interim Executive Director and Legislative Counsel. For further information on upcoming legislative issues, contact him at MAG Headquarters, 938 Peachtree St., Atlanta, GA 30309; 800-282-0224.

sion of the patient's right of privacy. The Association feels that before spending the money to establish this system, Georgia should implement AMA's PADS II Program. PADS II has the multiple advantages of providing the needed information for law enforcement at much less cost, preserving the patient's right of privacy, and not affecting the physician's position.

### **The Prescribing and Dispensing of Drugs by Advanced Practice Nurses**

The Attorney General issued an opinion last May that nurses may not prescribe or dispense drugs through the use of protocols. This has created problems for public health departments across the state, particularly with programs like family planning and hypertension clinics.

MAG recognizes the difficulties of public health and is attempting to negotiate with both DHR and the Georgia Nurses Association to develop a reasonable package to support in the 1989 session of the General Assembly. One of the major requirements of MAG is that any protocols that are developed must be controlled by the Composite State Board of Medical Examiners. Physicians must retain control over medical acts.

### **Tort Reform**

There is still much to be done in the area of tort reform, notwithstanding the advances made in 1987.

MAG has decided that the most critical problem facing physicians in the tort area faces obstetricians the most. Ever-increasing legal liability associated with the practice of obstetrics is driving insurance premiums up and doctors out. Because of the growing liability threat, 58 physicians in Georgia so far this year have dropped obstetrics from the services they provide. This is causing especially severe problems in rural Georgia, where 67 counties now have no doctor or hospital providing obstetrical care for expectant mothers. Therefore, MAG will develop legislation that will address obstetricians; although the exact structure has not been decided.

### **Child Health Services Act**

This legislation, proposed and heavily supported by the pediatricians, would provide mandatory premium insurance benefit coverage of 15 visits for birth to age 5, including well-baby care, physicals, etc. In the past, MAG has supported the concept but resisted supporting a law change.

MAG has worked hard this summer in an attempt to convince insurance companies to voluntarily adopt this coverage, with the understanding that the Association would support a law change if the companies failed to act. It now appears that they will not make the voluntary changes, and MAG will try to seek the law change in 1989.

### **Continuing Medical Education**

MAG is planning to have legislation introduced in the General Assembly that would mandate a number of continuing medical education hours as a condition of re-licensure. Our MAG Committee on CME is studying proposals for a minimum number of hours — and will probably settle on 40 credit hours per 2-year period.

MAG has always encouraged voluntary physician participation in CME and has generally spoken against mandatory CME, given the lack of documentation that participation in CME invariably improves a physician's competence. A recent survey has shown that physicians are taking more continuing education than will likely be mandated by law.

However, because of the growing insistence by the public for some mandated minimum of continuing education for physicians, the MAG Board has voted to work with the Georgia Academy of Family Physicians to develop a reasonable CME bill for introduction at the proper time.

### **AIDS**

Last year's AIDS bill has created problems for physicians, particularly surgeons. Since a patient must be given the opportunity to refuse an HIV test, physicians cannot be sure that they can make an accurate diagnosis or prescribe proper treatment. For surgeons, the inability to test for HIV may actually be life-threatening — both to the patient

and to the physician. Many physicians have asked that the decision to test for HIV be made a medical decision. Such a bill may be introduced this year.

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**Other health professions have realized that political involvement brings practice expansion, legislated respect, increased income. . . .**

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### **Physical Therapy Practice Expansion**

Passing the Senate in 1987 and dying in the House in 1988, a bill was presented by the physical therapists that would delete the current legal requirement that prior to initiating treatment, a physical therapist must have a consultation with a physician. This would allow for the independent practice of physical therapy. MAG has strongly opposed the expansion of physical therapy. The Association feels very strongly that only physicians have the training to properly diagnose patients.

### **Advanced Nurses Mandatory Insurance**

The proposal, which died in the 1988 session, would mandate that all advanced practice nurses be reimbursed by third party carriers for their services when policies cover reimbursement for services for which they were licensed to render.

MAG has consistently opposed in general the mandating of health insurance coverage, especially with regard to advanced nurses. If this proposal passed, healthcare costs would increase at a faster rate than they currently are.

**A**s you can see, the 1989 General Assembly will have ample opportunity to intrude into your practice *if you let it*. Decide today that your practice is worth preserving, and call your legislators. Preventive medicine is what your practice needs, and both you and your patients will feel better for your involvement.



# Third Party Payors' View of AIDS

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## **This discussion is designed to assist Third Party Payors in responding to the concerns AIDS presents in their communities.**

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**E**STIMATES OF THE POTENTIAL COSTS of treating AIDS patients vary greatly, as do forecasts of the number of individuals likely to be HIV infected and those who will develop clinical symptoms. With so much uncertainty, AIDS challenges the health care system, and indeed, society as a whole, to respond appropriately. One Third Party Payor of national prominence, working with an Advisory Panel of senior staff, has developed a Resource Document on AIDS to provide a comprehensive review of the issues AIDS raises for Third Party Payors and to assist them in addressing those issues.

The Document focuses on key areas of concern to the Third Party Payor:

- the potential cost and financial impact of AIDS;
- medical policy issues, such as defining preexisting conditions for AIDS;
- confidentiality of subscriber information and other legal questions;
- management of patient care costs related to AIDS;
- federal and state legislative and regulatory action;
- public relations issues and opportunities; and
- human resources issues for Third Party Payors as employers.

This discussion is designed to assist Third Party Payors in responding to the concerns AIDS presents in their communities. Variations by area in the numbers of AIDS cases in the community and among the Payor subscribers, combined with local differences in treatment costs and availability of community resources, make it necessary for each Payor to tailor its analysis and response to its local situation.

### **Resource Document Highlight**

Much of the concern about AIDS is focused on how the cost of care provided to AIDS patients will be financed and how access to needed care can be assured.

This discussion provides a methodology for using available data to estimate the cost of AIDS. The cost analysis, based on estimates of enrollment looking ahead to the next 3 to 4 years, indicates that relatively few Third Party Payors are likely to incur claims costs that will be an appreciable proportion of total ex-

penses. The greatest proportions of costs will be concentrated in a small number of states. However, all Third Party Payors will need to tailor these estimates to local circumstance and assess their own level of financial risk. Financial impact will be a function of many factors in addition to the absolute number of cases and per case costs. Therefore, the most accurate estimates will be those that are locally derived using realistic assumptions and the best available data.

Third Party Payors generally treat AIDS not as a special case but the same as any other disease. This view subjects AIDS to the same underwriting procedures, actuarial treatment, and medical policy as any other critical disease. The findings of this document support this approach. Specific AIDS-related medical policy questions, such as coverage for the use of blood tests, autologous blood transfusions, and payment for experimental drugs, can be addressed by applying the same technical decision rules that underlie medical policy for other critical diseases.

**T**he unusual profile of AIDS — its present association in this country with homosexuality and intravenous drug use — creates opportunities for discrimination against people infected by HIV. Such discrimination may be subject

to legal review and penalty. Analysis of the legal considerations for Third Party Payors in developing policies and procedures for AIDS indicates that any actions applicable only to subscribers or applicants with AIDS — or at high risk of HIV infection — should be avoided. Third Party Payors may find it useful to review and, where necessary, strengthen their policies on confidentiality. Finally, in every aspect of employment relations, Third Party Payor employees with HIV infection or AIDS should not be treated differently than any other employees with life-threatening illnesses.

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**The Third Party Payor must understand that AIDS and HIV-related illness should be subjected to the underwriting and actuarial treatment, medical policy guidelines, and confidentiality rules that govern all Payor practices.**

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This analysis of AIDS and, specifically, the issues AIDS raises for the Third Party Payor, indicates that current practices normally provide opportunities to adequately respond to AIDS. Importantly, individual case management or individual benefits management for AIDS patients can help the Third Party Payor in managing AIDS costs.

Further, the analysis of legislative activity indicates that there is a need for informed leadership on AIDS policy at local and state levels, a role that the Third Party Payor is in a unique position to fill.

**Special Considerations for AIDS Coverage**

As leaders in health care financing, Third Party Payors have made health care coverage broadly available in their communities. Concern about the potential costs of AIDS and adverse selection may challenge the Payors' ability to maintain practices that make coverage widely accessible.

The Third Party Payor must understand that AIDS and HIV-related illness should be subjected to the underwriting and actuarial treatment, medical policy guidelines, and confidentiality rules that govern all Payor practices.

AIDS may require special efforts in educating and informing subscribers, however, developing individual benefits management programs and responding to the needs and concerns of its community.

AIDS presents a wide spectrum of problems that are beyond the scope of health insurers. Persons with AIDS often require many services, including housing, social support services, financial planning, and financial assistance. A significant proportion of AIDS patients are homeless, indigent intravenous drug abusers who require many costly services and have no resources to pay for them.

Thus, AIDS must be viewed within a broad perspective, considering both subscribers' needs and the public policy issues AIDS presents. The uneven distribution of AIDS cases across the country renders AIDS a more pressing problem in

some areas, and for some communities, than for others. Third Party Payors should develop comprehensive approaches to the concerns AIDS presents in their communities which incorporate the following recommendations.

**Recommendations**

1. Treat AIDS and HIV-related illnesses as any other disease, subject to current underwriting and actuarial treatment, medical policy guidelines, and confidentiality rules that govern all Third Party Payor practices.
2. Advise and assist community and public agencies to:
  - education subscribers, employees, and the community about AIDS and the prevention of HIV infection;
  - develop networks of support services needed by AIDS patients;
  - advise and assist local public agencies in addressing AIDS.
3. Establish or strengthen case management programs to enable subscribers with AIDS to receive care in the setting most appropriate to their medical needs.
4. Evaluate the adequacy of methods for protecting confidential information and initiate programs as necessary.
5. Encourage accurate and timely reporting of AIDS cases on claims and billing forms.
6. Estimate and plan for the anticipated cost of AIDS-related claims.
7. Review their employment practices to assure that they are not unfairly discriminatory regarding AIDS.
8. Work with state government leaders to promote a strong public health response to AIDS.



# Repeat Teen Deliveries in Fulton County

Bess Jones, M.D., M.P.H.

## Introduction

**T** EEN PREGNANCY and parenting is a national problem. According to recent data, the USA leads nearly all other developed nations of the world in rates of teenage pregnancy, abortion, and childbearing, even though it has comparable rates of sexual activity.<sup>1</sup> Birth rates to teens ranged from 3 per 1000 in Japan to 52 per 1000 in the USA.<sup>2</sup> The USA teen pregnancy rate at 96 per 1000 is more than double that of five other industrialized western countries.<sup>3</sup> Comparative data from the Centers for Disease Control (CDC) show that even though pregnancy and fertility rates for 15 to 19 year olds in the USA decreased between 1974 and 1980 and fertility rates for females aged 12 to 14 also decreased, the pregnancy rates for those younger teens actually increased.<sup>4</sup>

## Abstract

**T** HIS STUDY INVESTIGATED the characteristics of the teenage females who had repeat deliveries at Grady Memorial Hospital in Atlanta. Profiles of the teen mothers and the implicated fathers are presented. Results show that these girls had a mean age of 17.8 years and were 95% black and single. About 70% were from low-income families, and 72% had either a mother or sister who was also a teen mother. The implicated males were 15-30 years old, and 46% were in the 20-22 year age group. Seventy-seven percent of these girls did contracept immediately after the first pregnancy, but 50% discontinued after less than 6 months, even though 92% state that this was an unplanned pregnancy. This suggests a lack of motivation in preventing a repeat pregnancy. Intervention strategies based on augmentation of motivation should be explored.

Trends in Fulton County, GA, parallel those nationally. There are approximately 46,000 girls between the ages of 10 and 19 in Fulton County. About 40% live in the service areas for the Health Department Teen Clinics which dispense various health services, including contraception, to about 12% of these teen

At the time of writing, Dr. Jones was a Preventive Medicine Resident at Morehouse School of Medicine in Atlanta. She is now with the DeKalb County Health Department. Send reprint requests to her at 1660 New Hope Rd., Atlanta, GA 30331.

girls.<sup>5</sup> The national trend of decreasing birth rates was also seen in Fulton County. The number of teen pregnancies actually declined at a rate of approximately 2% per year for the 5-year period between 1979 and 1984. Between 1984 and 1985, however, the pregnancy rate increased by 7% overall. The 10 to 14 year olds experienced the greatest changes, as preg-

nancy rates here increased by 13%, and abortion rates increased by 22%.<sup>6</sup> A large number of these were repeat pregnancies culminating in repeat deliveries.

Nationwide, one-third of all births to teen mothers represent repeat deliveries.<sup>3</sup> The trend is even more marked in certain areas of Fulton County where in 1985, of 1673 deliveries to teen mothers at Grady Memorial Hospital, 614 or 37% were repeat deliveries.<sup>5</sup>

The adverse consequences of adolescent childbearing have been documented. Economically, families headed by teen mothers are more likely to be poor, as these young mothers are most often cut off from opportunities for adequate education and job skills development.<sup>7</sup> There is also excess mortality and morbidity for both the young teen mother and her infant.<sup>8</sup> Women who begin childbearing in their teens have more children, have them closer together, and are more at risk for the low birth weight babies than do women who delay parenthood.<sup>9</sup> Recognizing the high rate of repeat teen deliveries in Fulton County, this study was undertaken to characterize the female who had a repeat delivery and to suggest intervention strategies which may help circumvent some of these adverse consequences.

**Recognizing the high rate of repeat teen deliveries in Fulton County (37% in 1985), this study was undertaken to characterize the female who had a repeat delivery and to suggest intervention strategies which may help circumvent some of these adverse consequences.**

## Methods

### Subjects

The study was descriptive and dealt only with teen mothers with repeat deliveries. A case was defined as a repeat (having delivered one or more previous infants) delivery to a female, age 13-19 years old, and a resident of Fulton County. Interviews were done with teen mothers who delivered at Grady Memorial Hospital (GMH) in At-

lanta, GA, from January through mid-April of 1987. The interview consisted of a questionnaire developed for the study and administered to each case by a public health nurse. Each nurse was involved in the High Risk Intervention Project in which all infants of teen mothers are enrolled for intensive follow up. The interviews were done as an adjunct to this project at 4 to 6 weeks postpartum. Interviews were attempted on all cases delivering through mid-April. Sixty cases delivered during that time, and interviews were completed on 39 of these. Twenty-one cases were lost to followup due to unknown addresses. Of the 39 completed interviews, 37 were 16-19 years old. Twenty-one were 17 or 18 years old.

### Analysis

Selected characteristics of these girls were analyzed by percentage distribution in the total population of cases. All available responses were used in the measurement of sociodemographic and behavior characteristics. Additionally, 17 and 18 year olds were also analyzed separately in the measurement of sexual activity patterns.

## Results

A profile of 39 teens who had been interviewed for repeat delivery is shown in Table 1. Age range was from 15-19 years, with a mean age at 17.8 years; 64% were either 18 or 19 years old. They were 95% black and single, and 74% were not enrolled in school when this pregnancy occurred. Sixty-nine percent had just two deliveries, while 8% had four deliveries. No higher order deliveries or abortions were recorded in this group. Seventy-seven percent did use contraception (93% on the pill), but 50% of these continued for less than 6 months after the first delivery. Reasons for discontinuance of contraception were largely from side effects, either actual or feared. Yet the pregnancy was unplanned in 92%, abortion was considered in 41%, but adoption considered in only 10% of cases.

A profile of the fathers is shown in Table 1. Age range was from 15 to 30 years, with 46% in the 20 to 22 year group. The male was the father of the other children of the case 41% of the time; 49% were employed, and 67% provided financial help to the child.

**TABLE 1 — Distribution of Selected Characteristics of the Repeat-Delivery Mother and the Baby's Father, Fulton County, GA, January-April, 1987**

<i>Characteristics</i>	<i>Number (%)</i> <i>N = 39</i>	
Unmarried	37	(95)
Race: Black	37	(95)
White	2	( 5)
Number of pregnancies		
Two	27	(69)
Three	9	(23)
Four	3	( 8)
On contraception		
After first pregnancy	30	(77)
Duration, <6 months	15	(50)*
School dropout before this pregnancy	29	(74)
This was unplanned pregnancy	36	(92)
Considered abortion this time	16	(41)
Considered adoption for this baby	4	(10)
Father's characteristics		
Age: 15-16	1	( 3)
17-19	9	(23)
20-22	18	(46)
23-25	7	(18)
26-30	4	(10)
Father of other children of case	16	(41)
Employed	19	(49)
Providing financial support	26	(67)

\*Based on N=30



A distribution of sociodemographics and behavior characteristics are shown in Table 2. About 70% of teen mothers with a repeat delivery were from low-income families. Furthermore, 68% of those parents did not complete high school. Fifty-six percent of these girls reported regular (at least once a month) church-going. About 70% of teen mothers reported having at least one female role model (mother or sister) as a teen mother (Table 2). Thirty-three percent had both mother and sister as teen mothers.

Table 3 shows the distribution of sexual activity patterns among cases. When all age subjects are considered, 62% of cases initiated sex before age 15, and 82% had two or more partners. When only 17 and 18 year olds are considered, these patterns are even more striking, as 71% initiated sex early, and 86% had multiple partners.

Discussion

Characteristics of the teen who is most likely to repeatedly sustain unintended pregnancy and delivery have been reported in the literature. Most of these characteristics (such as being urban, black, from a large one-parent family in which the mother or a sister was also a teen parent) are also associated with a low socio-economic status.<sup>10, 11</sup> It is difficult to disentangle the effects of poverty in such a situation.

This study showed that the Fulton County teen who had a repeat pregnancy and delivery at Grady Memorial Hospital during January through mid-April 1987 was poorer than her teen peers, with both parents as high-school dropouts. She was herself likely to be a high school dropout after the first delivery, and had either mother, sister or both as teen parents. Both postpartum withdrawal from school and having sisters with increased rates of childbearing have been associated with repeat pregnancy among school age mothers.<sup>12, 13</sup> Similar results were found in this study. There was also a very strong association with both early sexual activity and experience with multiple partners, especially among the older girls. Earlier studies have shown that the poorer girls do begin earlier sex,<sup>10</sup> although not

TABLE 2 — Distribution of Sociodemographics and Behavior Characteristics Among Teens with Repeat Deliveries, Fulton County, GA, January-April, 1987

Factors	Number of Subjects	% with Factor
From welfare families	(32)	69
No parent completed high school	(39)	68
Church-goers	(39)	56
Female role models as teen parents		
Both mother and sister		33
Mother or sister		72

TABLE 3 — Distribution of Sexual Activity Patterns Among Teens with Repeat Deliveries, Fulton County, GA, January-April, 1987

Sexual Activity	Number of Subjects	% With Factor
Became active before age 15		
All subjects	39	62
17 and 18 year-old subjects only	21	71
Two or more partners		
All subjects	39	82
17 and 18 year-old subjects only	21	86

**It appears that this group of girls was insufficiently motivated to prevent a repeat pregnancy. . . . Having another baby may, at best, confer upon this unfortunate teen the only personal and social rewards within her grasp. At worst, an unplanned pregnancy may represent merely the path of least resistance.**

necessarily more frequent sex than their more affluent peers.

While most girls contracepted after the first pregnancy, most discontinued after less than 6 months for various reasons, few of which involved inaccessibility to contraceptive methods. If appears that this group of girls was insufficiently motivated to prevent a repeat pregnancy, a conclusion reached in an earlier study about a similar group of girls.<sup>14</sup> For such a girl, the opportunities lost from a subsequent birth may be negligible. Even with a high school diploma, jobs for these girls are almost nonexistent. Having another baby may, at best, confer upon this unfortunate teen the only personal and social rewards within her grasp. At worst, an unplanned pregnancy may represent merely the path of least resistance. If lack of motivation is a key factor, effective intervention would involve identification of the high risk teen and strategies based on augmentation of motivation.

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# MRI UPDATE

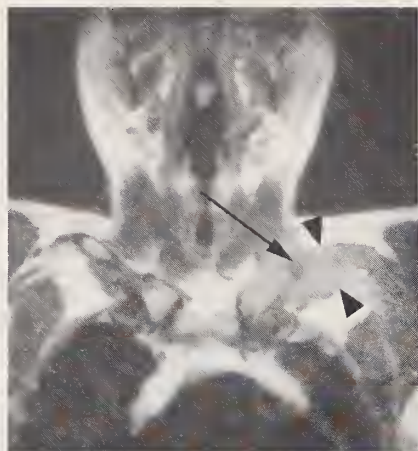


Figure 1

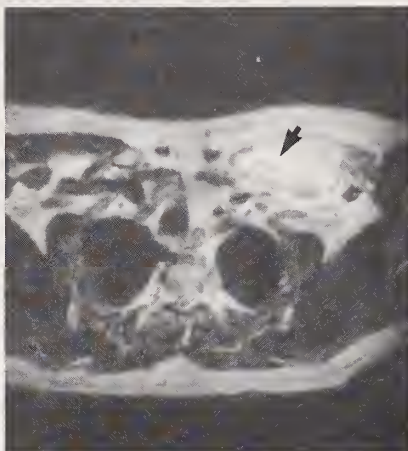


Figure 2

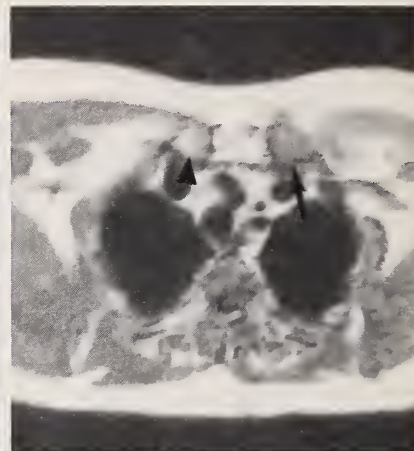


Figure 3

**HISTORY:** This patient is a 45 year old male who, on minor trauma, felt a popping sensation in his left sterno-clavicular region. Diffuse swelling developed and progressed down the left anterior chest wall over the next few weeks. A CT scan demonstrated a fracture of the midportion of the clavicle with minimal asymmetry of the soft tissues.

**MRI FINDINGS:** Coronal images demonstrated disruption of the midportion of the left clavicle (Fig. 1, long arrow) with intermediate signal intensity material extending into the adjacent muscles (arrowheads). Transverse T2 weighted images

(Fig. 2) show an area of increased signal intensity in the region of the clavicular fracture with extensive intermediate signal intensity material extending into the surrounding muscles. The high signal area most likely represents a hematoma surrounding the fracture (short arrow). The more diffuse intermediate signal represents diffused blood and/or edema in the surrounding muscles. T1 weighted images (Fig. 3) demonstrated low signal in the region of the clavicle near the sternoclavicular joint (small arrow, compare to high signal of right clavicle, arrowhead). The low signal indicates a bone marrow replacing process. Given the

history of fracture following minor trauma, low signal intensity within the left clavicle increases suspicion of underlying malignancy rather than post traumatic edema. Biopsy showed undifferentiated carcinoma.

## MRI HIGHLIGHTS:

While the fracture and minimal asymmetry of the soft tissues can be identified on the CT scan, this case illustrates the superior soft tissue contrast differentiation of MRI. Changes that are difficult to appreciate on the CT scan become obvious on MRI, which is rapidly becoming the method of choice for evaluating occult soft tissue abnormalities.



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# Surgical Treatment of Abdominal Aortic Aneurysms Using Cell Saver

James M. Freeman, M.D, Michael H. Roberts, M.D., Andrew S. Donnan, P.A.C.

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**We have found that the cell saver allows us to perform 60% of elective surgery without transfusion and also allows us to more adequately flush grafts and vessels without net blood loss.**

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## Material and Methods

We present 100 consecutive cases of abdominal aortic aneurysm, treated by a single surgical practice in a community hospital without house staff. The group includes 80 elective procedures and 20 emergency procedures. Statistics are broken down into these groups in Table 2.

The patients were largely unselected. Patients were denied surgery on the basis of severe disabling systemic disease, not thought

to have a prognosis of over 5 years, or mental deterioration. Ages varied from 44-91. Most patients presented with signs and symptoms of associated disease.

Emergency cases were so classified when surgery was undertaken for repair on an urgent basis because of pain or hemodynamic disturbance associated with aneurysms. Emergency cases were further divided into categories based upon operative findings.

## Preoperative Evaluation

The initial assessment consisted of a careful history and physical examination. Objective preoperative diagnosis was confirmed by ultrasound or CAT scan. If significant arterial occlusive disease of the distal vessels was present, aortograms were performed to plan associated procedures and assure adequate runoff of distal anastomoses. Other indications for aortogram included suspicion of origin above the renal arteries, unstable severe hypertension, and suspected bowel ischemia.

Evaluation of associated cerebrovascular disease was initially

**I**T HAS BECOME INCREASINGLY obvious over the past 25 years that abdominal aortic aneurysm is, with few exceptions, a surgical disease. Szilagyi<sup>1,2</sup> and others<sup>3</sup> have clearly documented the high mortality associated with nonsurgically treated abdominal aortic aneurysm. In this study, published in 1972, patients who were refused surgical treatment were followed for 10 years. In the first year, 38.9% died by rupture and 69.4% ruptured at the end of 2 years. At the end of 5 years, 91.7% ruptured. Additional studies have confirmed the high incidence of rupture, although most had a somewhat lower incidence of rupture. Even aneurysms of relatively small size, <6 cm., have 19-40% chance of rupture within 5 years. Initial surgical series used rather strict criteria for operability. Long-term follow-up data frequently revealed that mortality in those initially denied surgical treatment was largely due to rupture of the aneurysm.<sup>4</sup> Operative mortality and morbidity has steadily declined over this period of time, with improvement in preoperative evaluation and perioperative management.

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carried out by history, auscultation, and arteriography. More recently, non-invasive duplex imaging, spectral analysis, and periorbital doppler exams have been used to screen patients with symptoms or bruits. If critical lesions are present, carotid endarterectomy is carried out preoperatively.

Coronary artery disease is evaluated by history. If the patient has significant angina, coronary arteriograms are carried out. The usual criteria for CABG is used to decide whether to correct the coronary lesions prior to resection of the aneurysm.

Similar evaluations are made of pulmonary, renal, and other associated disease processes. Patients are denied surgery only if the quality of life is poor (i.e., senile dementia) or life expectancy is less than 5 years. Liberal use of consultants is used perioperatively.

### Operative Management

Invasive monitoring with arterial and Swan Ganz lines enables the anesthesiologist to maintain optimum cardiac function throughout the procedure. Intraoperatively, NTG drips have largely replaced nitroprusside. Anesthesiologists, experienced in the management of CAD and CABG, have contributed greatly to the safety of vascular surgery in general. Operative technique has become relatively standard. The principals of minimal dissection, endo-aneurysmorrhaphy, and isolation of bowel from suture line have been supplemented in the past few years with use of the cell saver.

We have found that the cell saver allows us to perform 60% of elective surgery without transfusion and also allows us to more adequately flush grafts and vessels without net blood loss (Table 3).

The cell saver used is Electromedics, Model RT795. The suction is used throughout the procedure. Heparin is used to prevent clotting before and after the operation. Cells are washed and returned to the patient. Average turn-over time is 5 minutes. The only untoward effect that we have noted is that during infusion of cells after Heparin has been reversed, fre-

**TABLE 1 — Operative Mortality for Repair of Intact Abdominal Aortic Aneurysms.**

Year	Authors	Number of Patients	Operative Mortality
1975	Hicks, et al <sup>5</sup>	113	4.2%
1975	Thompson, et al <sup>6</sup>	108	5.5%
1976	Volpetti, et al <sup>3</sup>	254	0.8%
1977	Young, et al <sup>7</sup>	123	5.7%
1977	Scobie, et al <sup>8</sup>	137	4.0%
1978	Baird, et al <sup>8</sup>	160	5.6%
1978	Gordon-Smith, et al <sup>8</sup>	51	0%
1979	Crawford, et al <sup>9</sup>	329	3.0%
1986	Freeman & Roberts	80	0%

**TABLE 2 — Results of Surgical Treatment of Aortic Aneurysm, Albany, 1986**

Abdominal aneurysm Repair	Number of Patients	Number of Deaths	% Death
Elective	80	0	0
Emergent	20	6	30
TOTAL	100	6	6

Abdominal aneurysms	Elective	Emergent	Total
Number of patients	80	20	100
Average age	67	71	69
Maximum age	84	90	90
Minimum age	48	50	48
Number of males	62	12	74
Percent male	78	60	74
Number of blacks	3	1	4
Percent black	4	5	4

quently the ACT will become prolonged and require small additional increments of Protamine.

The eighty patients in whom elective repair was carried out varied in age from 48 to 84 years, with an average age of 67. There was a high incidence of associated vascular disease.

There were no operative deaths, and the average hospitalization was 8 days. It is interesting to note that on those patients in which the cell saver was used, the average stay was 2 days less than on those in which it was not. Complications were minimal and were successfully dealt with in each incidence (Table 4).

Analysis of the emergent patients allows them to be divided into three categories based on operative findings.

Six patients were found to have no external evidence of leak or rup-

ture. Frequently, there was hemorrhage within the vessel, with fresh clot formation. There were no deaths in this group.

Ten patients presented with retroperitoneal hemorrhage in varying degrees of hemodynamic instability. There was one operative death in this group.

The most devastating group presented with free perforation into the peritoneal cavity. The patients were invariably in profound shock and usually never developed satisfactory hemodynamic parameters until the aorta was camped above the ruptured aneurysm. Cardiopulmonary resuscitation was necessary during induction on two patients. Five of six patients in this group died.

Complications were more frequent, and hospitalization prolonged, and more expensive in emergent patients.



TABLE 3 — Blood Loss Comparative Figures, Abdominal Aortic Aneurysm Surgeries, Albany, 1986

	ELECTIVE		EMERGENT	
	Auto transfusion used	Auto transfusion not used	Auto transfusion used	Auto transfusion not used
No. of patients	33	47	6	14
Percent of patients	41	59	30	70
Average amount auto blood	1180cc	NA	3060cc	NA
Maximum amount	3500cc	NA	10,700cc	NA
Minimum amount	300cc	NA	300cc	NA
Average blood loss	590cc	1870cc	1350cc	4700cc
Maximum loss	3000cc	5400cc	5500cc	<10,000cc*
Minimum loss	150cc	400cc	150cc	500cc
No. patients receiving bank blood	12*	44*	4	14
Percent receiving bank blood	36	94	67	100
Percent not requiring transfusion	64	6	33	0

\* 5 out of 12 had admission Hct <33%

† 4 out of 44 had admission Hct <33%

‡ 3 patients with <10 l, blood loss

Autotransfused patients averaged 900cc banked blood when transfusion was needed while non-autotransfused patients averaged 1690cc. banked blood when transfusion was needed. 53% less banked blood was given to autotransfused patients than non autotransfused.

Discussion

Our current series demonstrates several important points. The increasing safety of elective aneurysm replacement is demonstrated in a community hospital setting. The instance of rupture of small (i.e., less than 5 cm.) aneurysms is significant and probably results in higher mortality and morbidity than elective replacement of all significant aneurysms. Crawford<sup>7</sup> has recently recommended surgery for all aneurysms which are twice the normal diameter of the affected vessel. In view of the documented risk of rupture and current operative risk, this would seem a much better treatment than observing these aneurysms until they produce symptoms or significantly enlarge.

Preoperative evaluation was primarily based on clinical evaluation. Routine coronary arteriograms were not performed. Coronary arteriograms were utilized when indicated clinically by history and occasional EKG findings. With careful anesthesia management, this has been demonstrated as a safe method of preoperative evaluation.

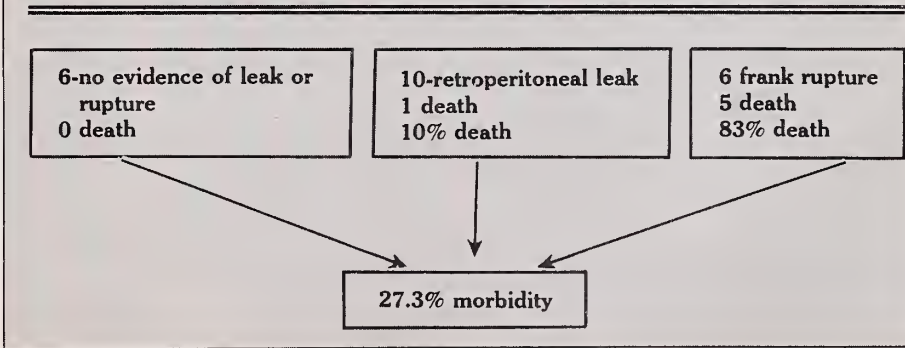
Utilization of a cell saver has proven to be both economically and medically beneficial to the patient

TABLE 4 — Abdominal aortic aneurysm repair, 100 patients, Albany, 1986

Elective 80 patients	Emergent 20 patients	Complications
70 (86%)	7 (35%)	No Complications
0	3	Urine, Bun & Cr
4	9	prolong vent
1	2	Microemboli
2	2	Acute occlusion femoral
2	2	pneumonia
0	3	coagulopathy
0	6	death
1	0	jaundice*

\* patient received banked blood

TABLE 5 — Results of Abdominal Aortic Aneurysm Operative Findings, 100 Patients, Albany, 1986



population. With the present spectra of AIDS so much in the public eye, and the old and known risk of hepatitis, we are now more than ever, obligated to avoid unnecessary transfusions. This series demonstrates that this can be accomplished in over 50% of the aneurysm resections. The overall mortality rate, while very acceptable, could have been improved by reducing the number of emergency procedures by earlier detection and elective replacement of all significant aneurysms.

### Summary

This group of patients confirms the conclusions, recorded by many other groups with abdominal aortic aneurysm, that this should be treated surgically except in rare incidences. It also demonstrates that satisfactory results can be achieved in community hospitals with adequate facilities. The size of the ruptured aneurysms varied from 4 cm. to 10 cm. The small size of some of the ruptured aneurysms confirms the trend to extend the surgical treatment to all significant aneurysms.

The cell saver is a valuable adjunct in the care of these patients, and in addition to avoiding bank blood transfusions, seems to reduce overall morbidity.

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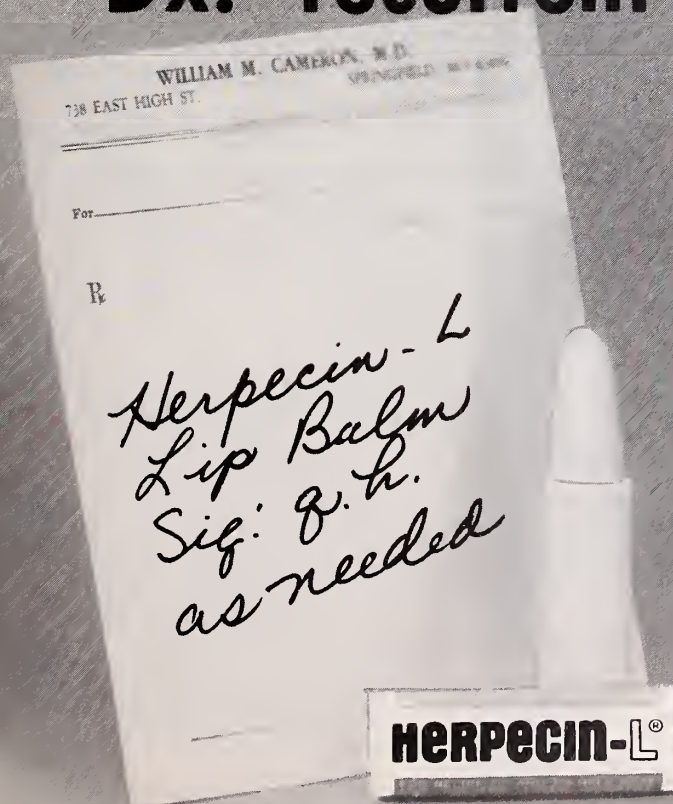
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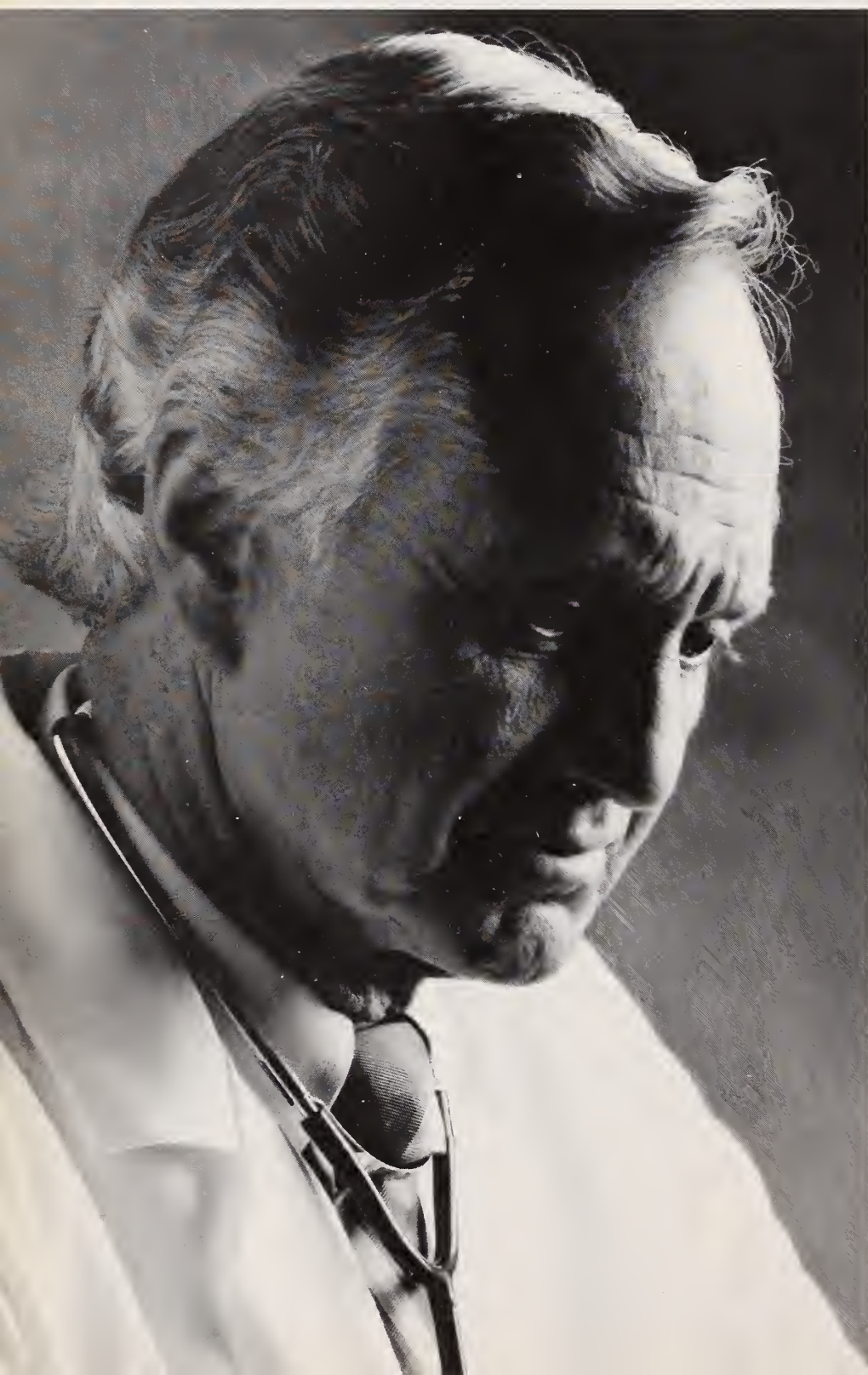
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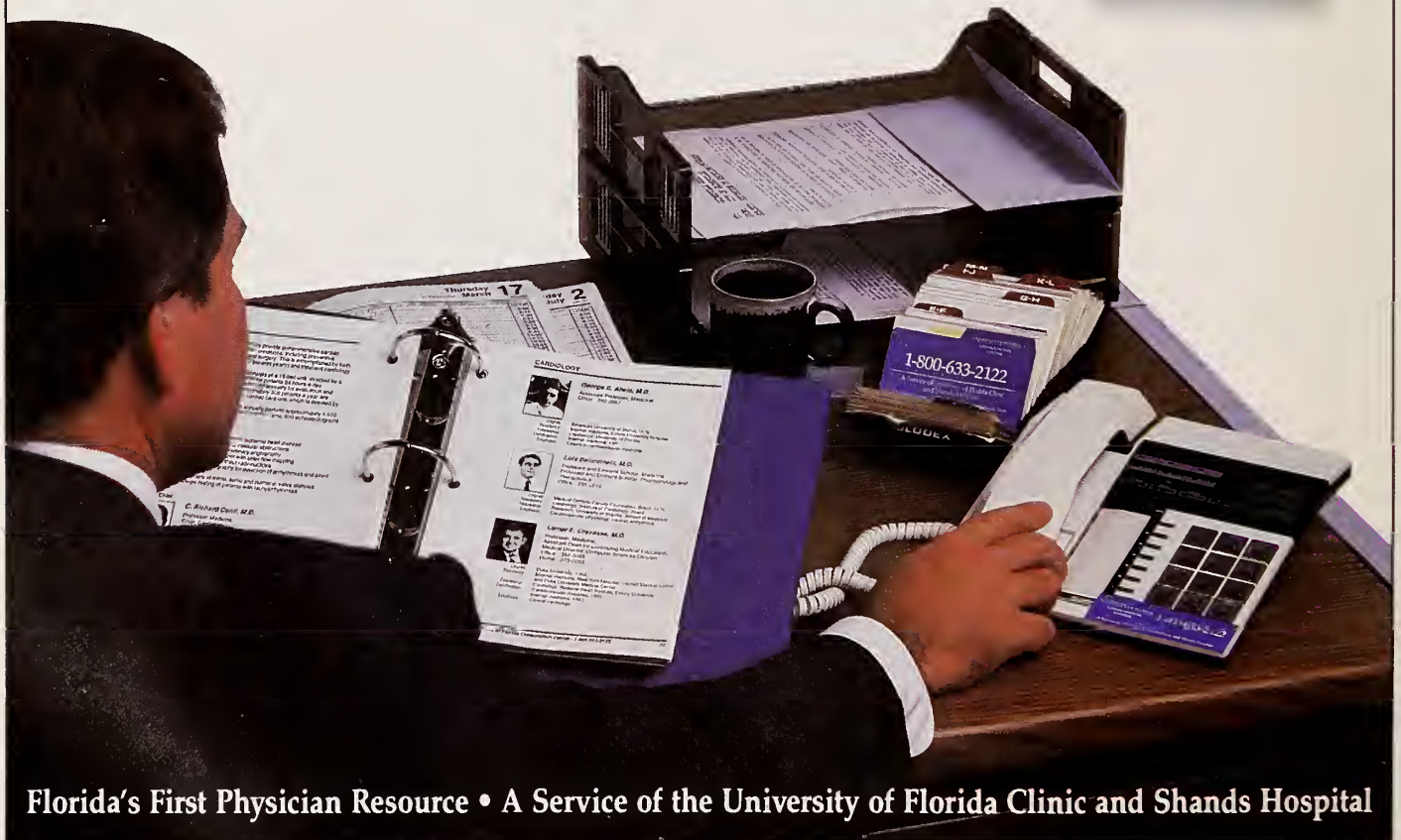
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# Toward 9 by '90: Reducing Infant Mortality

Charlotte M. Druschel, M.D., Brian J. McCarthy, M.D., Louise Floyd, R.N.,  
Michael R. Lavoie, R. Keith Sikes, D.V.M.

## Introduction

**T**HE 1990 NATIONAL objective for infant mortality is 9 deaths per 1000 live births, with no race or ethnic group having a rate in excess of 12 per 1000.<sup>1</sup> The Georgia Department of Human Resources (DHR) recently began an effort to achieve this national objective, calling it "Toward 9 by '90." We felt that insight into what interventions should be emphasized could be gained by determining where the reduction in infant mortality rates had taken place over the past 2 decades. We hypothesized that subpopulations may presently experience infant mortality rates comparable to the 1960s and have yet to achieve the reductions experienced by others. By concentrating on these subpopulations with interventions known to be effective, we might further reduce these mortality rates.

## Methods

We calculated mortality rates for

## Abstract

**WE EXAMINED GEORGIA'S PROGRESS toward the 1990 objectives for reducing infant mortality rates in the United States and determined where the greatest potential lay for further reducing infant mortality. We compared infant mortality rates for three time periods and three birthweight groups using linked birth-death vital records. We compared low birthweight and mortality rates among six sociodemographic groups to estimate the potential for reduction in the mortality rates.**

**The majority of reduction (96%) in these rates was due to improvements in birthweight specific mortality rates; only the white low birthweight rate decreased. Blacks and whites have similar birthweight specific infant mortality rates for low birthweight infants. Large gaps still exist in race-specific low birthweight rates and the mortality rates for normal birthweight infants.**

**Reductions in black infant mortality rates accounted for 58% of the reduction in the total rates. Reduction in the mortality rates in infants who weighed >2500 grams at birth accounted for 48% of the reduction, while infants weighing ≤1500 grams and 1501-2500 grams accounted for 26% each. Although the gap in mortality rates between white and black infants increased during this time period, we believe there is great potential for further reduction in the IMR.**

1960, 1974-1976, and 1980-1982 from linked birth-death files for live births to Georgia residents. Three-year time periods were chosen for more stable rates. For 1960, we calculated Georgia rates from the national birth-death linkage done for that year.<sup>2</sup> A computer tape of live births is not available, thus limiting denominators to those published in the National Center for Health Statistics data books.<sup>3</sup> In this time period, the category of black infants includes other non-white infants, but it is still over 98% black.

We calculated rates for 1974-76 and 1980-82 using Georgia's linked birth-death file. For these time periods, the total includes all races, and black refers to black infants only. Additional data linked to the birth-death file include neonatal intensive care unit admissions. The DHR manually links admission logs from the units annually to the birth-death files.

The definition of low birthweight

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in 1960,  $\leq 2500$  grams, differs slightly from the current World Health Organization definition of  $< 2500$  grams. Due to limitations of the 1960 denominator data, in this paper we define low birthweight as  $\leq 2500$  grams. We chose to use infant mortality for low birthweight infants instead of neonatal mortality which is traditionally used. Using infant mortality avoids the problem of the postponement of deaths from the neonatal to the postneonatal period brought about by exposure to neonatal intensive care units.<sup>4</sup> Where the data are available, we have divided low birthweight infants into two groups; those  $\leq 1500$  grams are very low birthweight, and those 1501-2500 grams are intermediate low birthweight. For the relative risks, white infant rates are the referent group.

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### **Almost all of the reduction in infant mortality rates resulted from improvement in birthweight-specific mortality rates.**

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Strategies for the reduction of infant mortality were grouped into seven categories. The categories are interventions directed at: modifying the pregnancy rates within high risk groups and thereby changing the sociodemographic profile of the birthing population, reducing the rate of very low birthweight infants, reducing the rate of intermediate low birthweight infants, increasing the survival of very low birthweight infants, increasing the survival of intermediate low birthweight infants, increasing the neonatal survival of the normal birthweight infant, and increasing the postneonatal survival of normal weight infants.

We divided the live births into three subpopulations according to two maternal sociodemographic variables: age and education. Group I are infants of mothers  $\geq 20$  years of age with  $\geq 13$  years of education;

Group II are infants of mothers  $\geq 20$  years of age with  $< 13$  years of education; and Group III are infants of mothers  $< 20$  years of age.

The potential for reduction in the infant mortality rates was calculated using white Group I infants as the reference. We applied the white Group I very low and intermediate low birthweight rates to each of five remaining groups. We multiplied the number of infants in each group by the group's birthweight-specific infant mortality rate for simplicity and because the rates were very similar. This gave us the number of deaths that would have occurred if the Group I rates were achieved. We then subtracted the number of deaths in each category from the number of deaths that actually occurred. This is the potential reduction in deaths or the excess number of deaths due to the difference in the birthweight distribution between Group I and the remaining groups. We applied a similar method to the normal birthweight infants, except we applied Group I birthweight-specific mortality rates.

#### **Results**

The total low birthweight rate has increased slightly, but white infants have experienced a change different than black infants. While white infants have had a slight decrease in low birthweight, black infants have had an increase for both groups of low birthweight infants (Table 1). For white infants, the improved low birthweight rate accounts for about 6% of the reduction in mortality. No improvement in black infant mortality rates can be attributed to an improved change in the low birthweight.

From 1960 to 1980-82, the total infant mortality rate decreased 57%. Mortality rates declined for both races, but more for white infants than black infants, 59% versus 55%, respectively (Table 2). Thus, the gap increased as shown by the increase in the relative risk of a black mother experiencing an infant death compared to a white mother (1.94 in 1960 to 2.13 in 1980-82).

Almost all of the reduction in infant mortality rates resulted from improvement in birthweight-specific mortality rates. The largest attributable percent reduction, 52%,

occurred in the normal birthweight infants and represented a 66% reduction in the infant mortality rates for this weight group. Intermediate low birthweight infants accounted for 29% of the reduction, and this represented a 71% reduction in their infant mortality rate. Very low birthweight infants accounted for 21% of the reduction (Table 2).

The relative contribution of different weight groups to improvements in infant mortality rates differed by race (Table 3). For white infants, the majority of the reduction results from improved survival of infants  $\leq 2500$  grams; both very low and intermediate birthweight infants accounted for 31% of the reduction. For blacks, very low and intermediate birthweight infants accounted for 7 and 29% of the reduction, respectively.

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### **The black-white gap (in infant mortality rates) exists because of two major factors, the higher low birthweight rate and higher mortality for normal birthweight infants. To achieve parity, both areas must be addressed.**

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For normal birthweight infants, the attributable percent reduction in infant mortality rates was higher in black than in white infants. The majority of the reduction, about 64%, occurred in the postneonatal period. Neonatal mortality declined 76%, and postneonatal mortality declined 70% for black normal birthweight infants. For white normal birthweight infants, the decline was 67% and 50%, respectively. While the relative risk of death would appear to be decreasing, in 1980-82, a normal birthweight black infant still had over twice the risk of dying in the postneonatal period than a white infant (Table 3).

For those infants weighing  $\leq 1500$  grams, black and white infants have



similar survival and overall reduction, 41% and 47%, respectively, in each of the three time periods (Table 3). Mortality for intermediate low birthweight infants decreased 70% for both black and white infants. There were no neonatal intensive care units (ICUs) in 1960; the first opened in the 70s. For infants weighing 1501-2500 grams, both races had similar survival in the first and last time periods. However, in 1974-76, black infants had a survival advantage. During this period, black infants also had higher neonatal ICU admission rates than white infants, 11% versus 18%.

In summary, we expected a higher attributable percent reduction for the very low birthweight infants than the 23% we found. We were surprised to find that normal and intermediate low birthweight infants accounted for 52% and 29% of the attributable percent reduction, respectively. The reduction that occurred in the low birthweight and neonatal period we attributed to the increasing and extensive use of neonatal intensive care. The high relative risk in black normal birthweight infants during the postneonatal period led us to believe that we may be missing a significant potential for reduction in these infants during this time period.

### Potential for Reduction

We found significant differences in the infant mortality rates among the three sociodemographic groups. These differences were even more exaggerated when examined by race (Table 4). White Group I infants had an infant mortality rate of 6 per 1000 as compared to 21.7 for black Group III infants. Black infants were more likely to be born to teenage mothers (29%) and mothers with less higher education (17%). Only 0.6% of white Group I infants, compared to 2.4% of black Group III infants, are  $\leq 1500$  grams at birth. Similar differences are seen in the intermediate birthweight infants. Differences in the birthweight-specific infant mortality rates for both the very low and intermediate low birthweight infants among the groups are small. However, more meaningful differences occur among the groups in the normal

**TABLE 1 — Race-Specific Low Birthweight Rates, Percent Change in Low Birthweight Rates For Three Time Periods, Georgia Resident Births**

	1960	1974-76	1980-82	% Change
<b>Race/Birthweight<sup>1</sup></b>				
<b>Total</b>				
Very Low	1.3	1.3	1.5	+15
Intermediate	7.1	7.3	7.1	0
Low	8.4	8.6	8.6	+2
<b>White</b>				
Very Low	1.1	0.9	1.0	-9
Intermediate	5.8	5.7	5.1	-12
Low	6.8	6.5	6.1	-10
<b>Black</b>				
Very Low	1.7	2.3	2.5	+47
Intermediate	9.0	10.9	10.5	+17
Low	11.5	13.2	13.0	+15

1. Birthweight groups: Very Low ( $\leq 1500$  gm)  
Intermediate (1501-2500 gm)  
Low ( $\leq 2500$  gm).

**TABLE 2 — Race Specific Infant Mortality Rates,<sup>1</sup> Percent Reduction and Attributable Percent Reduction<sup>2</sup> in Infant Mortality Rates for Three Time Periods, Georgia Resident Births**

	1960	1974-76	1980-82	% Reduction	Attributable % Reduction
<b>Race-Specific Infant Mortality Rates</b>					
Total	31.6	18.3	13.6	57	100
White	23.7	13.8	9.7	59	42
Black	46.0	26.7	20.7	55	58
<b>Birthweight<sup>3</sup> Rates</b>					
Very Low	779.2	574.3	434.3	44	26
Intermediate	105.1	46.8	30.4	71	26
Normal	15.8	7.2	5.3	66	48

1. Rates per 1000 live births

2. Attributable Percent Reduction is the reduction in the total infant mortality rate that resulted from the reduction in the race specific or birthweight specific infant mortality rate.

3. Birthweight groups: Very Low ( $\leq 1500$  gm)  
Intermediate (1501-2500 gm)  
Normal ( $> 2500$  gm).

birthweight infants in the neonatal and postneonatal period.

We believe that the greatest potential for reduction in infant mortality rates lays where there is the greatest difference among the groups for the categories of infant mortality strategies. This is best illustrated in Tables 5 and 6. The highest relative risk is for normal birthweight infants in the postneonatal period (column labeled "Post"). Black Group III infants are almost 8 times more likely to experience death than white Group I. The relative risks for very low and intermediate low birthweight in-

fants are the next highest difference. Although some potential for reduction exists in strategies that reduce neonatal mortality in normal birthweight infants, there is little meaningful difference in the strategies stressing increased survival of the low birthweight infants (Table 5).

We estimate the potential for reduction in the infant mortality rates to be 7.0 per 1000 live births. Although 2.8 per 1000 of this potential for reduction is associated with interventions to prevent very low birthweight infants, a significant reduction, 2.2 per 1000, can be

**TABLE 3 — Race and Birthweight-Specific Infant Mortality Rates,<sup>1</sup> Relative Risk, Percent Reduction, and Attributable Percent Reduction,<sup>2</sup> in Infant Mortality Rates for Three Time Periods, Georgia Resident Births**

	1960	1974-76	1980-82	% Reduction	Attributable % Reduction Race (Total)
<b>Race/Birthweight<sup>3</sup></b>					
<b>White</b>					
Very Low	810.0	561.0	426.0	47	28 (12)
Intermediate	102.0	56.0	30.0	70	29 (12)
<b>Normal</b>					
Neonatal	5.5	2.6	1.8	67	19 ( 8)
Postneonatal	4.6	3.0	2.3	50	24 (10)
<b>Black</b>					
Very Low	744.0	583.0	440.0	41	23 (13)
Intermediate	108.0	38.0	30.0	71	25 (15)
<b>Normal</b>					
Neonatal	9.2	3.6	2.2	76	16 ( 9)
Postneonatal	17.6	6.7	5.1	70	36 (21)
<b>Relative Risk<sup>4</sup></b>					
Very Low	0.9*	1.0	1.0	NA	
Intermediate	1.1	0.7*	1.0	NA	
<b>Normal</b>					
Neonatal	1.7*	1.4*	1.2*		
Postneonatal	3.8*	2.3*	2.2*		

1. Rates per 1000 live births

2. Attributable Percent Reduction is the reduction in the total infant mortality rate that resulted from the reduction in the race specific or birthweight specific infant mortality rate.

3. Birthweight groups: Very Low ( $\leq 1500$  gm)  
Intermediate (1501-2500 gm)  
Normal ( $>2500$  gm).

4. The Relative Risk (RR) for each indicator is calculated using white women and infants as the reference population.

$$RR = \frac{\text{Rate in Black Infants}}{\text{Rate in White Infants}}$$

\* 95% CI does not include 1

achieved in the postneonatal period for normal birthweight infants (Table 6). Smaller but appreciable reductions can be achieved in the neonatal period which are equally divided between the very low and the normal birthweight infants. Black Group II infants could contribute the greatest reduction as a group. It is not surprising that a 1.7 per 1000 drop in the total infant mortality rate could be achieved by concentrating on the black Group III rate.

### Discussion

Although Georgia's mortality rates have declined for all birthweight and race groups, gaps still exist. Overall, the black-white gap increased due to an increase in very low birthweight infants among blacks. Since 1965, the national trend for the rate of low birthweight has been slightly downward, and the majority of the

decline is for intermediate low birthweight infants. Whites have had a slight decline in very low birthweight, while blacks have had a slight increase in this group.<sup>5</sup> This is similar to the trends in Georgia. If the birthweight distribution for blacks had remained at the 1960 rates, the total infant mortality for blacks would have been 17 per 1000 instead of 20.7 with a relative risk of 1.8. It is difficult to say whether blacks have experienced a true increase in low birthweight. Much of the increase is likely due to more complete reporting of births.

The use of the 1960 definition of low birthweight ( $\leq 2500$  rather than  $<2500$ ) may actually have avoided a possible bias. In an analysis of vital records data for quality and completeness, Davis noted digit preference in the recording of birthweight.<sup>6</sup> Using a definition of  $<2500$ , some low birthweight infants might

be categorized as normal birthweight. The extent of the bias probably varies among the time periods, diminishing in later time periods as awareness of low birthweight increased.

Much has been written about the improved survival of low birthweight infants. This has generally been attributed to improvements in obstetric care, the effectiveness of neonatal ICUs, and the development of regionalization.<sup>7</sup> Normal birthweight infants also seem to have benefited. The reduction in neonatal mortality of these infants is a major factor in the decline in overall infant mortality. A study of obstetric services and perinatal mortality in Norway found that normal birthweight infants had a greater improvement in mortality with improved obstetric care than low birthweight infants.<sup>8</sup>

Despite these improvements, a gap still exists between blacks and whites. It has been noted previously in Georgia and other areas that normal birthweight black infants have higher mortality than white infants.<sup>9-11</sup> Both black and white infants in this group had greater percent reductions in the neonatal period than the postneonatal, a period when mortality is thought to be more responsive to medical technology.

A large black-white differential exists in the postneonatal period. Gaps in the postneonatal period may reflect several performance problems of access to the health care delivery system. As most neonatal deaths are early, it is likely that these infants are already in the formal health care delivery system. In the postneonatal period, the infants must be brought back into the system to be treated. Parents must be encouraged to bring infants early for care and must not be penalized for doing so. Areas with higher than expected rates of postneonatal mortality or where rates have not been declining should consider reviewing what health care is available for infants in addition to well child care. Particular care should be taken to avoid situations where parents are punished for seeking care sooner than needed. If an infant is found not to be ill, a negative



**TABLE 4 — Infant Mortality Strategy Indicators: Infant Mortality Rate,<sup>1</sup> Very Low Birthweight Rate,<sup>2</sup> Low Birthweight Rate,<sup>2</sup> Birthweight Specific Mortality Rate,<sup>3</sup> by Race and Sociodemographic Group<sup>4</sup> Georgia, 1979-81**

Sociodemographic Group	Infant Mortality Strategy					Intermediate Neonatal ICU	Neo Birthweight-Specific Infant Mortality Rate	Post Birthweight-Specific Postneonatal Mortality Rate
	Infant Mortality Rate	Profile Percent Total (Race)	Birthweight Distribution For Very Low Birthweight	Birthweight Distribution For Intermediate Birthweight	Birthweight Specific Infant Mortality Rate ≤1500	Birthweight-Specific Infant Mortality Rate 1501-2500	Birthweight-Specific Normal Mortality Rate ≥2500 +	Birthweight-Specific Postneonatal Mortality Rate ≥2500 +
White Group 1	6.0	20 (32)	0.6	3.9	390	33	1.5	0.9
White Group 2	9.6	33 (52)	0.8	5.7	459	33	1.9	2.6
White Group 3	13.9	10 (16)	1.2	7.8	458	40	2.2	4.1
Black Group 1	15.4	6 (17)	2.0	9.2	444	26	1.9	2.8
Black Group 2	18.6	20 (55)	2.0	11.4	402	36	2.5	5.2
Black Group 3	21.7	11 (29)	2.4	13.6	421	32	2.2	6.9
TOTAL	12.7	100 (NA)	1.3	7.7	425	34	2.0	3.3

1. Rate is per 1000 live births.

2. Rate is per 100 live births expressed as percent.

3. Rate is per 1000 live births in a given weight group.

4. Previously defined groups:

Group 1: Women ≥20 years of age  
≥13 years of education

Group 2: Women ≥20 years of age  
≤12 years of education

Group 3: Women ≤19 years of age

**TABLE 5 — Infant Mortality Strategy Indicators: The Relative Risk<sup>1</sup> of Infant Mortality, Very Low Birthweight, Low Birthweight, Birthweight Specific Mortality, by Race and Sociodemographic Group<sup>2</sup> Georgia, 1979-81**

Sociodemographic Group	Infant Mortality Strategy					Intermediate Neonatal ICU	Neo Birthweight-Specific Infant Mortality Rate	Post Birthweight-Specific Postneonatal Mortality Rate
	Infant Mortality Rate	Profile Percent Total (Race)	Birthweight Distribution For Very Low Birthweight	Birthweight Distribution For Intermediate Birthweight	Birthweight-Specific Infant Mortality Rate ≤1500	Birthweight-Specific Infant Mortality Rate 1501-2500	Birthweight-Specific Normal Mortality Rate ≥2500 +	Birthweight-Specific Postneonatal Mortality Rate ≥2500 +
White Group 1	1.0	20 (32)	1.0	1.0	1.0	1.0	1.0	1.0
White Group 2	1.6	33 (52)	1.3	1.5	1.2	1.0	1.3	2.9
White Group 3	2.3	10 (16)	2.0	2.0	1.2	1.2	1.5	4.5
Black Group 1	2.6	6 (17)	3.3	2.3	1.1	0.8	1.3	3.1
Black Group 2	3.1	20 (55)	3.3	2.9	1.0	1.1	1.7	5.7
Black Group 3	3.6	11 (29)	4.0	3.5	1.1	1.0	1.5	7.7
TOTAL		100 (NA)	2.2	2.0	1.1	1.0	1.3	3.7

1. The Relative Risk for each indicator is calculated using White Group 1 women and infants as the reference population.

$$RR = \frac{\text{Rate in specific sociodemographic group}}{\text{Rate in White Group 1}}$$

2. Previously defined groups:

Group 1: Women ≥20 years of age  
≥13 years of education

Group 2: Women ≥20 years of age  
≤12 years of education

Group 3: Women ≤19 years of age

response from health care personnel may cause the parents to delay the next time with unfortunate results.

Numerous studies have found that low birthweight black infants have better neonatal survival than white infants of the same birth-

weight;<sup>9, 10</sup> less has been written about infant survival. The infant mortality rates presented here have generally been very similar for both

**TABLE 6 — The Potential for Reduction,<sup>1</sup> in the Infant Mortality Rate for Each Infant Mortality Strategy, by Race and Sociodemographic Group,<sup>2</sup> Georgia, 1979-81**

Group	Infant Mortality Rate	Profile	Infant Mortality Strategy				Neo	Post	Total
			Birthweight Distribution For Very Low Birthweight	Birthweight Distribution For Intermediate Birthweight	Neonatal ICU	Intermediate Neonatal ICU			
White Group 1	6.0	23 (31)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
White Group 2	9.6	38 (53)	0.2	0.2	0.2	0.0	0.1	0.5	1.2
White Group 3	13.9	11 (16)	0.4	0.1	0.1	0.0	0.1	0.3	0.9
Black Group 1	15.4	5 (18)	0.4	0.1	0.1	0.0	0.0	0.1	0.6
Black Group 2	18.6	15 (54)	1.1	0.4	0.1	0.1	0.2	0.7	2.6
Black Group 3	21.7	8 (28)	0.8	0.3	0.1	0.0	0.1	0.5	1.7
<b>TOTAL</b>	<b>12.7</b>	<b>100 (NA)</b>	<b>2.8</b>	<b>1.1</b>	<b>0.5</b>	<b>0.1</b>	<b>0.4</b>	<b>2.2</b>	<b>7.0</b>

1. The Potential for Reduction is calculated using White Group I women and infants as the reference population and is expressed per 1000 total live births. For example, if black group 3 infants experienced rates comparable to white group I rates, the total infant mortality rate would decrease by 1.7 per 1000, 0.5 per 1000 of which would be in the postneonatal period to infants who weighed  $\geq 2500$  gms at birth.

2. Previously defined groups:

- Group 1: Women  $\geq 20$  years of age  
 $\geq 13$  years of education
- Group 2: Women  $\geq 20$  years of age  
 $\leq 12$  years of education
- Group 3: Women  $\leq 19$  years of age

racess, except for the marked difference in the 1974-76 period for larger low birthweight infants.

Better access to neonatal ICUs may explain the survival advantage of intermediate low birthweight black infants in 1974-76. Neonatal ICUs tend to be in large metropolitan hospitals where blacks are likely to deliver, allowing better access to the units for these infants at a time when the concept of regionalization and transfer was embryonic. In 1974-76, over a quarter of black births were at tertiary centers, compared to 5% of white births. Very low birthweight black infants also had higher admission rates, but no survival advantage. Neonatal ICUs at that time were probably more effective for intermediate low birthweight infants.

In the 1980-82 period, neonatal ICU admission rates are similar for both races. Blacks are still twice as likely to deliver at tertiary centers, 31 versus 15% for whites. Over 31% of white very low birthweight infants, however, were born at tertiary centers (41% of very low birthweight black infants were). In 1980-82, level II hospitals were providing care routinely for intermediate low birthweight infants. Forty-two percent and 45%, respectively, of white and black intermediate low birthweight infants were born at level II or III hospitals.

In 1980-82, the infant mortality rate for Georgia was 13.6. The rate for white infants was 9.7, very close to the 1990 objective; the rate for black infants of 20.7 would need to be reduced 42% to achieve a rate of 12. (If whites achieve a rate of 9 per 1000 and blacks a rate of 12, the rate for the state as a whole would be over 10 per 1000 because of the high percent of black births.) The black-white gap exists because of two major factors, the higher low birthweight rate and higher mortality for normal birthweight infants.<sup>10</sup> To achieve parity, both areas must be addressed.

Our comparison of group specific mortality rates provide considerable data for thought, particularly for postneonatal mortality. The very low and intermediate birthweight rates have been very resistant to change in the past 25 years. Therefore, when we consider the true potential for reduction, we must take into account where we have already been very successful at reducing birthweight-specific mortality rates. We have the medical expertise to lower the mortality of all normal birthweight infants. This would seem an obvious strategy, to apply what we know and assure that we are doing these things correctly.

For strategies directed at changing the birthweight distribution, it is less clear that we are doing the

right things. Basic research may provide some answers. New strategies should be proposed but should be properly evaluated before being implemented on a broad scale. The disparity in race-specific group low birthweight rates also suggests that interventions may not be carried out correctly. Before embarking on expensive research schemes or large scale clinical trials, we should be certain that the strategies we know to be effective in altering birthweight distribution are being done correctly.<sup>12</sup>

### Conclusion

Considerable reduction in infant mortality rates can be achieved through focusing on interventions

**We have the medical expertise to lower the mortality of all normal birthweight infants. This would seem an obvious strategy, to apply what we know and assure that we are doing these things correctly.**



**For strategies directed at changing the birthweight distribution, it is less clear that we are doing the right things.**

directed at the normal birthweight infant in the postneonatal period. To prevent an increase in infant mortality and a widening of the gap between groups, survival for specific birthweight groups must be maintained. Access to higher level care and neonatal ICUs must continue; both low and normal birthweight infants benefit. Black and white infants have similar birthweight specific survival for low birthweight infants. For infants in the postneonatal period, there must be ready access to medical care. Further study of cause-specific mortality in the postneonatal period will highlight the strategies which need to be emphasized.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

## Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

## Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

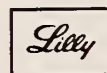
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
  - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
  - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
  - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes.
  - Transient fluctuations in leukocyte count (especially in infants and children).
  - Abnormal urinalysis; elevations in BUN or serum creatinine.
  - Positive direct Coombs' test.
  - False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

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## Pediatric Oncology Update

Deborah L. Carter, M.D., Elizabeth M. Kurczynski, M.D.

**T**HERE HAS BEEN AN EXPLOSION of knowledge in the field of pediatric oncology in the past 20 years, and some of the most impressive strides have been made in the treatment of Acute Lymphoblastic Leukemia (ALL). In 1965, fewer than 1% of patients with ALL were reported to be long-term survivors. Today, 95% of children with ALL will achieve remission and 80 to 85% will be cured. The overall cure rate for all acute leukemias (lymphoblastic and non-lymphoblastic) has improved to 50%.

Cancer is the leading cause of death from disease in children less than 15 years of age, and leukemia is the most common malignancy in this age group. Leukemia occurs at an incidence of 4/100,000/year, and 80% of these children will have ALL, while the remaining 20% will have Acute Non-Lymphoblastic Leukemia (ANLL). On the basis of these data alone, it is apparent that leukemia, although rare, is a significant disease of childhood, and, accordingly, there is much encouragement over the improved survival rates.<sup>1</sup>

Wilms' Tumor is another pediatric tumor which, over the past 20 years, has seen long-term survival increase dramatically from about 15% in 1950 to almost 90% in the 1980s. The first National Wilms' Tumor Study was started in 1969<sup>2</sup> and was the first

**‘The importance of the protocol concept cannot be overemphasized; it is the model for providing quality care to the pediatric oncology population.’**

protocol developed as a cooperative effort between the three pediatric oncology groups. Currently, almost every major pediatric oncology center in the U.S. and Canada treats patients according to the fourth Wilms' Tumor Study. As a result of the group studies, tumor histopathology has been modified.<sup>3</sup> Children who have the anaplastic or clear cell sarcoma variants are now known to have poorer survival rates and are, therefore, treated with more radiotherapy and more intensive chemotherapy, including Adriamycin and Cis-Platinum. In addition, staging has been refined, surgical guidelines improved, and therapy has been

decreased for children with favorable histology and Stage I or II tumors.<sup>4</sup>

A similar multidisciplinary approach to Rhabdomyosarcoma has produced a significant increase in cure rate since the first Intergroup Rhabdomyosarcoma Study was begun in 1972.<sup>5</sup> This tumor most commonly presents as a painless, rapidly growing subcutaneous mass but also occurs in the orbit, nasopharynx, parameningeal areas, genitourinary tract (including the botryoid histologic variant), and retroperitoneum. The improvement in survival rate from 55% in IRS-I to 65% in IRS-II was due to multimodal therapy. Early, aggressive surgery for both tumor removal and lymph node sampling for accurate staging is combined with intensive pulses of chemotherapy and radiotherapy to residual tumor. As with Wilms' Tumor, children with Stage I and II disease are now given less intense and shorter duration chemotherapy and experience cure rates of 80-95%.<sup>6</sup>

**W**hile the above two tumors continue to show improving survival rates, the prognosis for children with neuroblastoma has not changed much in the past 20 years. Children under 1 year of age at diagnosis have an 82% survival rate, but children who are over 2 have a survival rate of only

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10%.<sup>7</sup> Current research is studying the effect of the n-myc oncogene which is present in multiple copies in children with rapidly progressive neuroblastoma,<sup>8</sup> and the use of neuron-specific enolase levels as a prognostic factor. Some of the approaches currently being used for Stage IV patients are high dose melphalan therapy followed by bone marrow transplant from a sibling or the patient's own stored (autologous) marrow, high dose chemotherapy with total body radiation, and "second look" and occasionally "third look" surgery for more complete tumor removal.

The past 20 years have seen great strides in the diagnosis and treatment of non-Hodgkin's lymphomas. Improvements in immunologic typing have shown that most lymphoblastic lymphomas are of T cell origin and respond to intensive chemotherapy similar to that used for poor-prognosis ALL. The undifferentiated, Burkitt's, and histiocytic lymphomas are all B cell phenotypes and express surface immunoglobulins. The intensive multidrug chemotherapeutic protocols that are now being used for these children produce long-term survival rates of over 90% for localized disease, and 50-75% for extensive disease.

Other areas of childhood cancer have shown more modest improvements in survival. Brain tumors, osteogenic sarcoma, and Ewing's tumor have responded to earlier diagnosis and improved staging, but results are still disappointing. These tumors are frequently metastatic at diagnosis and far less responsive to chemotherapy than lymphomas and leukemias. We hope that these tumors, too, will yield to new and more effective

approaches that can best be tested in a multidisciplinary, cooperative group setting.

**‘The past 20 years have seen great strides in the diagnosis and treatment of acute lymphoblastic leukemia, Wilms’ Tumor, and non-Hodgkin’s lymphoma in children. The prognosis for those with neuroblastoma, however, has not changed much in this time period.’**

**W**hy has the outlook for these patients changed so dramatically over the past 20 years? The answer is multifactorial, but the most pivotal reason is the pediatric cooperative cancer group effort. Through these cooperative groups, pediatric oncology centers can pool their data and work toward providing these patients with the most efficacious, least toxic chemotherapeutic protocols. Other factors include: more accurate diagnostic methods, more sophisticated radiation therapy, more specific and aggressive chemotherapy, improved bone marrow transplantation technique, and the multidisciplinary approach to the pediatric cancer patient.

The importance of the protocol concept cannot be overemphasized; it is the model for providing quality care to the

pediatric oncology population.<sup>9</sup> In one study, data show that patients treated with an organized protocol had a 60% 5-year disease-free survival rate compared with a 19% 5-year disease-free survival for those not treated according to an organized protocol.<sup>10</sup>

These numbers speak for themselves and underscore this key element in the improvement of outcome in the pediatric oncology population. Through the efforts of the cooperative study groups, children with cancer are being cured and are growing into healthy adults. By the year 1990, one in every 1,000 young adults age 20 will be a childhood cancer survivor.

The future looks bright for pediatric oncology, and the hope is that the research efforts of the next several years will prove as productive as the last 20 years have been.

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## *A Primer on the Medicare/Medicaid Anti-Kickback Provisions*

*Robert N. Berg*

**I**N RECENT YEARS, there has been a marked increase in the quantity and scope of multi-physician and physician-hospital joint ventures — to build and own medical office buildings; to develop and own diagnostic centers and outpatient facilities; to own and operate reference laboratories; etc. Since, in many cases, the physician-owners participating in these joint ventures are also referral sources (referring patients or specimens to the facilities in which they have an ownership interest), physicians have had to assess the risk that their participation might violate the Medicare/Medicaid Fraud and Abuse statutes (the “anti-kickback provisions”). This Legal Page article takes a closer look at the relevant statutes and case law in this area.

### **General Statutory Framework**

Both the Medicare<sup>1</sup> and Medicaid<sup>2</sup> statutes contain broad prohibitions against the solicitation or receipt of kickbacks, bribes, rebates, or other remuneration in return for the referral of Medicare or Medicaid patients or services. Specifically, it is unlawful for any person knowingly and willfully to solicit or receive any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for

***‘This article discusses issues relevant to physician involvement in multi-physician or hospital-physician joint ventures and the questions concerning anti-kickback statutes that often arise.’***

referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the Medicare or Medicaid programs, or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or part under the Medicare or Medicaid program. It is also unlawful for any person knowingly or willfully to offer to pay or pay any remuneration in order to induce a person to make such a referral, purchase, lease, order, or arrangement.

This article was prepared at the request of the *Journal*. Mr. Berg is a partner in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Road, NE, Atlanta, Georgia 30326. Send reprint requests to Mr. Berg.

**T**here are two statutory exceptions to this general prohibition: First, the general prohibition against kickbacks is not applicable to a “discount or reduction in price obtained by a provider of services or other entity under [the Medicare or Medicaid statutes] if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the [Medicare or Medicaid statutes].”<sup>3</sup> In addition, the anti-kickback provisions are not applicable to “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services” under Medicare or Medicaid.<sup>4</sup>

Moreover, under the Medicare and Medicaid Patient and Program Protection Act of 1987,<sup>5</sup> the Secretary of the Department of Health and Human Services is required to issue final regulations specifying various types of commercial arrangements and payment practices which will *not* be subject to prosecution under the anti-kickback statutes. These regulations must be published in final form within 2 years of the enactment of the statute. Presently, draft regulations, prepared by the Office of Inspector General, are being considered by the United States

Department of Justice (the federal agency charged with responsibility for enforcing the Medicare/Medicaid penalty provisions), but it is not expected that these regulations will be finalized much before the August, 1989, deadline.

### **Application of the Anti-Kickback Provisions by the Courts and Regulatory Agencies**

Historically, the original anti-kickback provisions were enacted in 1972, to "provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions. . . ."<sup>6</sup> Since their enactment, the anti-kickback prohibitions typically have been applied in cases involving blatant kickback arrangements. For example, successful challenges have been brought against arrangements involving (i) the proposed payment of a 15% rebate by a clinical laboratory in exchange for the referral of Medicare and Medi-Cal business, (ii) the extraction of cash payments and alcohol by nursing home administrators from pharmacies and physical therapists in exchange for the referral of Medicaid business, and (iii) the solicitation and receipt of cash payments from a clinical laboratory in exchange for the referral of Medicare and Medicaid blood and tissue specimens.<sup>7</sup>

Additionally, the anti-kickback prohibitions have been applied to more complicated or disguised referral arrangements. For example, successful challenges have been brought against arrangements involving (i) payments by medical laboratories to administrators of medical clinics for specimen referrals, through the creation of separate

laboratories owned by bogus corporations, (ii) the payment of consulting fees by pharmacies to dummy management corporations, which funnelled the payments to nursing home owners, and (iii) the payment of "consulting fees" to physicians in return for laboratory referrals, with the fees held in escrow administered by a physician-owned corporation and, ultimately, used to purchase ownership of the laboratory.<sup>8</sup>

**I**n each of these cases, the arrangement involved was structured primarily for no legitimate reason, but rather to provide payments (kickbacks) to physicians or providers in return for the referral of patients or specimens, and thus supported a narrow interpretation of the anti-kickback prohibitions. This changed, however, in 1985, when the United States Court of Appeals for the Third Circuit decided the case of *United States v. Greber*.<sup>9</sup> In *Greber*, the Third Circuit held that payments intended to induce a physician to utilize the services of a particular diagnostic facility violated the provisions of the Medicare anti-kickback statute, regardless of whether those payments were intended also to compensate the physician for actual, valuable professional services rendered. In particular, the Court upheld the trial court's charge to the jury that "even if the physician interpreting the test did so as a consultant to [the diagnostic facility], that fact was immaterial if *a purpose* of the fee [paid by the diagnostic facility] to the physician was to induce the ordering of services [by the physician] from [the diagnostic facility]."<sup>10</sup> From this, the *Greber* case came to be read as perhaps standing for the proposition that

any payment by a health care facility to a physician which is motivated, *even in part*, by a desire to induce the physician to refer patients to the facility, may constitute an unlawful activity under the anti-kickback statutes.

***In spite of the current draft of the "safe harbor" regulations, there may still remain a significant number of legitimate joint venture activities between hospitals and physicians, or among physicians, which might be construed as or at least raise the possibility of being violative of the anti-kickback prohibitions.***

At about the same time as the *Greber* opinion, the Health Care Financing Administration (HCFA) (the federal agency charged with responsibility for administering the Medicare and Medicaid programs), in an intermediary letter,<sup>11</sup> indicated that payments made by durable medical equipment suppliers to respiratory therapists designed to induce those therapists to refer Medicare or Medicaid patients to the suppliers would violate the anti-kickback statutes, *whether or not the payments were made for services actually rendered*. In HCFA's view, an "opportunity to



generate a fee" was itself a form of remuneration, the payment of which, in return for the referral of Medicare or Medicaid patients, would violate the anti-kickback statutes. (Subsequently, through the issuance of a Program Memo, HCFA superseded this Intermediary Letter, specifically deleting the reference to "fee-generating opportunities.")<sup>12</sup>

As a result of the *Greber* case and the HCFA opinion, a tremendous amount of uncertainty has developed in the health care field; questions have arisen as to the applicability of the anti-kickback statutes to a wide variety of activities, ranging from percentage leases between facilities and physicians and physician incentive payments by hospitals, to waivers of Medicare co-payments and deductibles and hospital-physician joint ventures. In fact, based upon these concerns, many physicians and other health care providers have been hesitant to become involved in any arrangement which contains both (i) payments to the physicians, and (ii) referrals of patients by the physicians to the

payment source. Similarly, many physicians have elected to participate only in those joint ventures where the return to the investing physician is based *solely* on that physician's investment, rather than in any way on the volume or value of the physician's patient or specimen referrals.

## Conclusion

Until such time as the new "safe harbor" regulations are promulgated under the Medicare and Medicaid Patient and Program Protection Act of 1987, and/or until new judicial opinions further interpret the anti-kickback statutes, there will remain a great deal of uncertainty as to the exact boundaries of the Medicare/Medicaid anti-kickback provisions. Indeed, based upon the current draft of the "safe harbor" regulations, promulgation of these regulations may not remove a great deal of the uncertainty — there may still remain a significant number of legitimate joint venture activities between hospitals and physicians, or among physicians, which

might be construed as or at least raise the possibility of being violative of the anti-kickback prohibitions. At this point in time, however, physicians desiring to become involved in joint ventures must continue to assess the risk in each case that their involvement may also create potential exposure to liability under the anti-kickback statutes.

## Notes

1. 42 U.S.C. §1395nn(b).
2. 42 U.S.C. §1396h(b).
3. 42 U.S.C. §§1395nn(b)(3)(A), 1396h(b)(3)(A).
4. 42 U.S.C. §§1395nn(b)(3)(B), 1396h(b)(3)(B).
5. Pub.L. 100-93, effective August 18, 1987.
6. H. Rep. No. 92-231, 92d Cong., 2d Sess. (May 26, 1971), reprinted in 1972-1974 U.S. Code Cong. & Ad. News at 4989, 5093.
7. See, e.g., *U.S. v. Duz-mor Diagnostic Laboratory, Inc.*, 650 F.2d 223 (9th Cir. 1981); *U.S. v. Perlstein*, 632 F.2d 661 (6th Cir. 1980); *U.S. v. Hancock*, 604 F.2d 999 (7th Cir. 1979).
8. See, e.g., *U.S. v. Universal Trade and Industries, Inc.*, 695 F.2d 1151 (9th Cir. 1983); *U.S. v. Ruttenberg*, 625 F.2d 173 (7th Cir. 1980); *U.S. v. Tapert*, 625 F.2d 111 (6th Cir. 1980).
9. 760 F.2d 68 (3d Cir. 1985).
10. *Id.*, 760 F.2d at 71.
11. Intermediary Letter No. 84-9 [1984-1 Transfer Binder] CCH Medicare and Medicaid Guide, Para. 34,127 (September, 1984).
12. Program Memo No. B-85-2, [1984-85 Transfer Binder] CCH Medicare and Medicaid Guide, Para. 34,544 (January, 1985).

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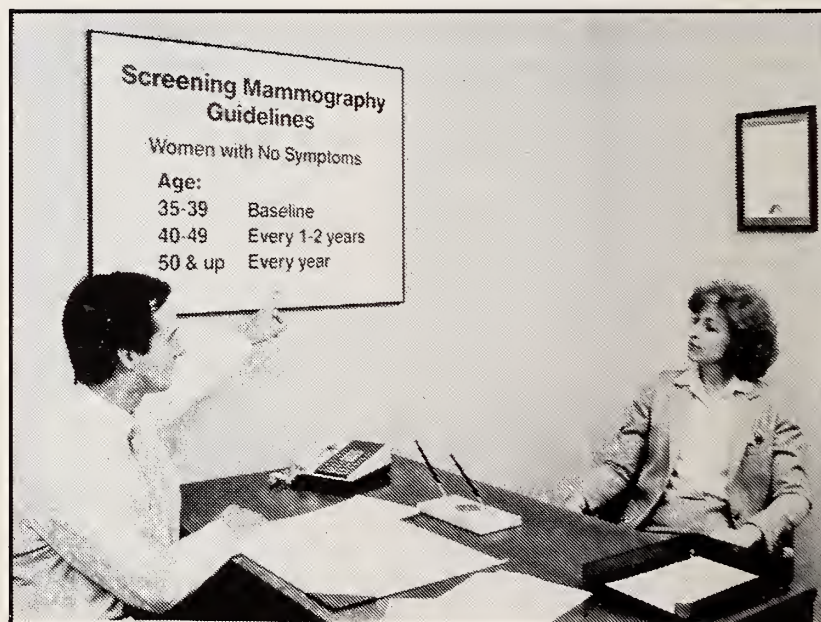
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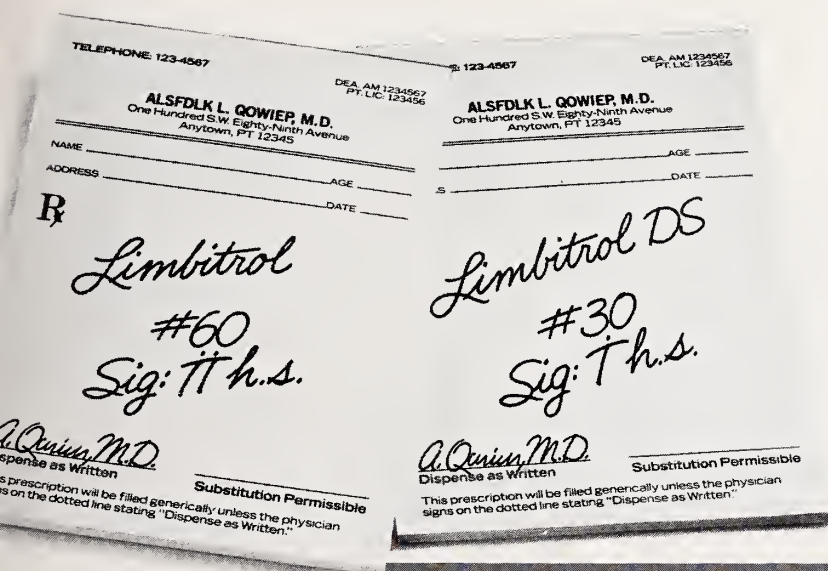
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Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

**Warnings:** Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Use in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

**Overdosage:** Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.



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In the depressed and anxious patient

# See Improvement In The First Week<sup>1</sup>

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose<sup>1</sup>
- ➡ First-week reduction in somatic symptoms<sup>1</sup>

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

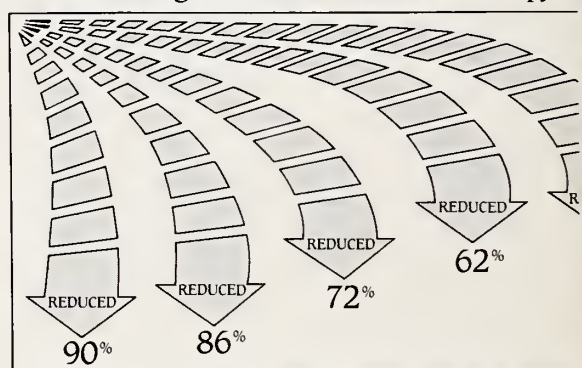
## Limbitrol<sup>®</sup>

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) (N)

## Limbitrol<sup>®</sup> DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) (N)

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy\*



VOMITING NAUSEA HEADACHE ANOREXIA CON:

\*Patients often presented with more than one somatic



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FEBRUARY 1989

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

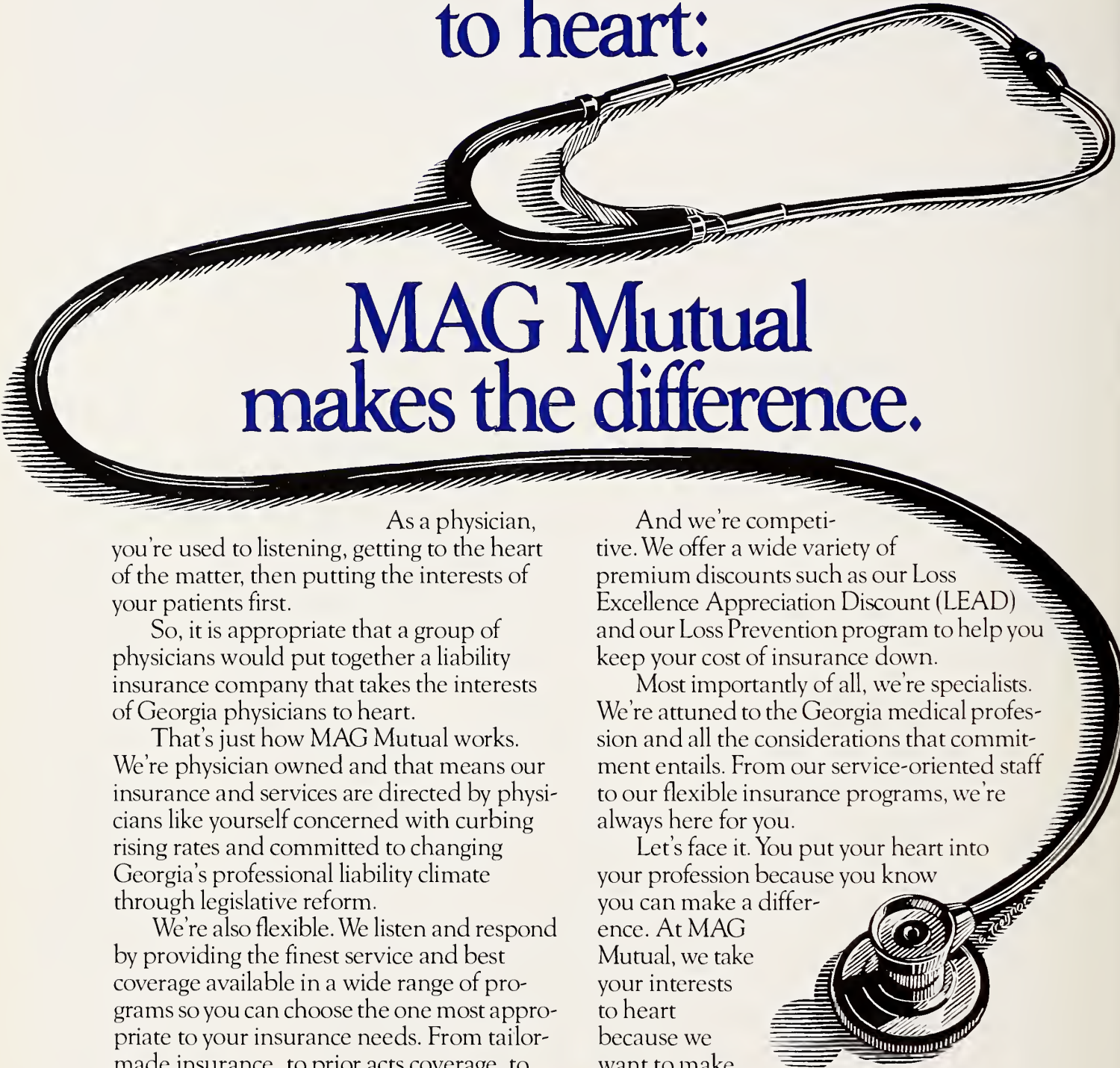
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*Surgical Management of Morbid Obesity*

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# The Future Effect Of AIDS On Your Insurance Plans

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That type of opportunity exists today in an area that is likely to be as volatile as the malpractice area has been. I am referring to nonguaranteed life and disability plans.

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\$250 Deductible

AGE	EMPLOYEE	FAMILY	AGE	EMPLOYEE	FAMILY
Under 35	\$ 50.00	\$157.00	Under 29	\$ 34.00	\$ 91.00
35-39	\$ 63.00	\$189.00	30-39	\$ 38.00	\$113.00
40-49	\$ 93.00	\$260.00	40-44	\$ 49.00	\$127.00
50-59	\$148.00	\$370.00	45-49	\$ 59.00	\$142.00
60-64	\$211.00	\$498.00	50-54	\$ 70.00	\$155.00
			55-59	\$ 84.00	\$169.00
			60-64	\$101.00	\$186.00

\*The "A + Rated" carrier's premiums would be slightly higher in the Atlanta area. Rates and contracts are subject to change. A number of options are available including Maternity, Prescription, Dental, etc. at additional premiums. All premiums are subject to underwriting acceptance.

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**THE COVER**

The larger illustration on the right depicts the gastric bypass. The smaller illustration shows the vertical banded gastroplasty which is currently the most popular surgical technique for treating morbid obesity.

Illustration by David Mascaro, Department of Medical Illustration, Medical College of Georgia.

# MRI UPDATE



Figure 1

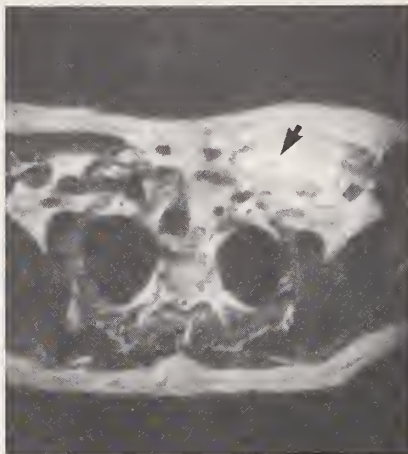


Figure 2

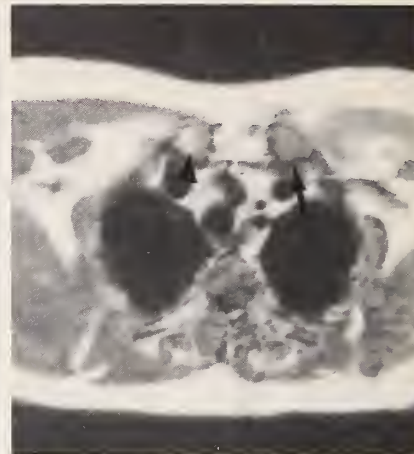


Figure 3

**HISTORY:** This patient is a 45 year old male who, on minor trauma, felt a popping sensation in his left sternoclavicular region. Diffuse swelling developed and progressed down the left anterior chest wall over the next few weeks. A CT scan demonstrated a fracture of the midportion of the clavicle with minimal asymmetry of the soft tissues.

**MRI FINDINGS:** Coronal images demonstrated disruption of the midportion of the left clavicle (Fig. 1, long arrow) with intermediate signal intensity material extending into the adjacent muscles (arrowheads). Transverse T2 weighted images

(Fig. 2) show an area of increased signal intensity in the region of the clavicular fracture with extensive intermediate signal intensity material extending into the surrounding muscles. The high signal area most likely represents a hematoma surrounding the fracture (short arrow). The more diffuse intermediate signal represents diffused blood and/or edema in the surrounding muscles. T1 weighted images (Fig. 3) demonstrated low signal in the region of the clavicle near the sternoclavicular joint (small arrow, compare to high signal of right clavicle, arrowhead). The low signal indicates a bone marrow replacing process. Given the

history of fracture following minor trauma, low signal intensity within the left clavicle increases suspicion of underlying malignancy rather than post traumatic edema. Biopsy showed undifferentiated carcinoma.

## MRI HIGHLIGHTS:

While the fracture and minimal asymmetry of the soft tissues can be identified on the CT scan, this case illustrates the superior soft tissue contrast differentiation of MRI. Changes that are difficult to appreciate on the CT scan become obvious on MRI, which is rapidly becoming the method of choice for evaluating occult soft tissue abnormalities.



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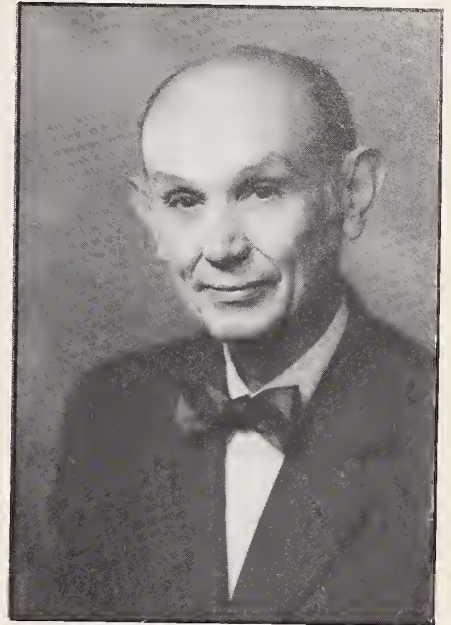
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### *Accentuate the Positive*

*Joseph P. Bailey, Jr., M.D.*

**O**UR PROFESSION is one that deservedly enjoys positive recognition for its contributions to mankind's well being. The risks involved in the practice of medicine are real, as is the long and arduous road to the attainment of membership in its ranks. Today, the controls and concerns about the cost of medical care have generated tremendous turmoil for everyone. In great part this has been generated by governmental intervention attempting to pay for the indigent and aging American's care.

Amidst this furor has been the tendency to express negative opinions about our decision in choosing medicine as a career, and yet we all revere both its practice and our colleagues who place service above self. The voiced negatives, however, have a great influence on all that we hear.

There has been a definite decrease in applicants to medical schools throughout our nation. These schools constitute the potential for our future and must have young men and women of the very highest calibre in order to maintain the rich heritage of our profession.

Recognizing the reality of the previous comments, let us join in imparting to all that we meet, the satisfaction and positive attributes of being a Doctor of Medicine, but particularly encourage the qualified young person who is interested in Medicine. Today's student is tomorrow's physician.

*Joseph P. Bailey, Jr.*

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## PERSONALS

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**Jesse Ray Grant, M.D.**, and  
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 Physicians (AAFP) Family Practice  
 Teachers Award during the  
 Georgia Academy's 40th Annual  
 Scientific Assembly in Atlanta.  
 These awards are resented  
 annually by the AAFP in  
 recognition of family physicians  
 who have volunteered 75 hours or  
 more of their time teaching in any  
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### *DeKalb CMS*

**John Heard, M.D.**, of Decatur,  
 and Omar Najjar, M.D., received  
 an American Academy of Family  
 Physicians Family Practice  
 Teachers Award.

### *Dougherty CMS*

**Edwin E. Flournoy, Jr., M.D.**,  
 a family practitioner in Albany,  
 received an American Academy of  
 Family Physicians Family Practice  
 Teachers Award during the  
 Georgia Academy of Family  
 Physicians' 40th annual Scientific  
 Assembly in Atlanta.

**Charles E. Finney, M.D.**, of  
 Albany, has been granted  
 diplomate status by the American  
 Society of Bariatric Physicians.

### *Lumpkin CMS*

**Richard A. Wherry, M.D.**, a  
 family practitioner in private  
 practice in Dahlonega, recently  
 became a President of the  
 Georgia Academy of Family  
 Physicians. He has served the  
 Georgia Academy in various  
 leadership capacities including:

President-elect; Vice President;  
 Committee on Maternal,  
 Adolescent, and Child Care,  
 Chairman; and Board of Directors,  
 member, to name just a few.

Dr. Wherry was appointed by  
 Governor Harris to the State  
 Council on Maternal and Infant  
 Care. He also served as Alternate  
 Delegate to the national  
 organization, the American  
 Academy of Family Physicians.

At this year's awards ceremony,  
 Dr. Wherry was also presented  
 with an American Academy of  
 Family Physicians Family Practice  
 Teacher Award.

### *Richmond CMS*

**Paul McDonough, M.D.**, of  
 Augusta, was recently honored as  
 one of 107 leading U.S.  
 obstetrician/gynecologists in the  
 October, 1987, issue of *Good  
 Housekeeping* magazine. The  
 doctors cited in the list were  
 compiled by a medical researcher  
 who interviewed 250 department  
 chairmen and section chiefs  
 across the country and asked  
 them to name the most  
 outstanding obstetricians/  
 gynecologists in six areas of  
 expertise. The areas of expertise  
 included: general obstetrics and  
 gynecology, gynecologic cancer,  
 maternal-fetal medicine,  
 reproductive endocrinology,  
 infections, and genetics. Only  
 doctors who actually see patients  
 were considered, although some  
 of them have a limited patient  
 load or act primarily as a  
 consultant.

Dr. McDonough is chief of the  
 reproductive endocrinology  
 section and professor at the  
 Medical College of Georgia. He is  
 a member of the American Board  
 of obstetrics and Gynecology,  
 reproductive endocrine division.

## DEATHS

**Clyde L. Crawford, M.D.**, of  
 Atlanta, died last November of  
 colon cancer. He was 84.

Dr. Crawford had practiced  
 general medicine and surgery at  
 St. Joseph's, Crawford W. Long,

and Piedmont Hospitals during  
 his 56-year career. He was a  
 graduate of Emory University and  
 the Medical College of Virginia.

**Robert Mackay Howard, M.D.**,  
 died last May. He was 56.

A native of Savannah, Dr.  
 Howard earned a bachelor's  
 degree from Duke University in  
 1952 and graduated from Duke  
 University Medical School. He  
 served his internship in  
 anatomical pathology at Emory  
 University Hospital and was  
 assistant resident in anatomical  
 pathology at Emory University  
 Hospital.

In 1962, Dr. Howard joined  
 Howard Clinical Laboratory,  
 where he worked until his  
 retirement in 1971. He was a  
 member of numerous professional  
 associations.

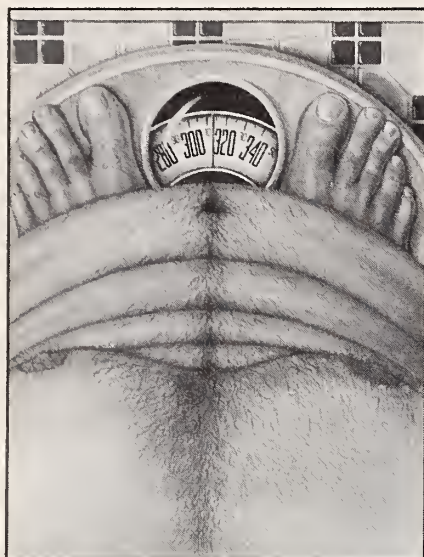
**Lonnie Richard Lanier Jr.,  
 M.D.**, of Savannah, died last  
 August at the age of 61 after a  
 short illness.

The McRae native was a  
 graduate of the Medical College of  
 Georgia and served his internship  
 at University of Texas Medical  
 Branch in Galveston, and his  
 residency in Obstetrics and  
 Gynecology at MCG. Dr. Lanier  
 began practicing in Savannah in  
 1955 and was a staff member at  
 both Candler General Hospital  
 and Memorial Medical Center. He  
 was a fellow of the American  
 College of Obstetricians and  
 Gynecologists. He has also served  
 in the U.S. Army Medical Corps  
 during the Korean War. He was a  
 former member of Savannah  
 Yacht Club, Savannah Rose  
 Society, and American Orchid  
 Society.

## PIP

Physicians participating in  
 MAG's Physician Involvement  
 Program (PIP) for the 1989  
 Legislative Session will meet at  
 the Ramada Capitol Plaza in Rm.  
 1203 at 8:30 a.m. on Tuesdays,  
 Wednesdays & Thursdays for the  
 rest of the Session. If you would  
 like to participate, call Donna  
 Glass at MAG, 404-876-7535 or  
 800-282-0224.





## *Surgical Management of the Morbidly Obese: Some Personal Comments*

*Seymour J. Rosenbloom, M.D., F.A.C.P.*

**M**ORBID OBESITY, or malignant obesity, is conventionally defined as an absolute (100 lb. or relative) 100% excess in weight above an ideal weight. This ideal weight is statistically associated with a maximum life expectancy. There is a convincing amount of clinical and epidemiologic data that document the association of higher morbidity and mortality rates in morbidly obese patients. These patients have higher rates of hypertension, diabetes mellitus, ventilatory dysfunction, immune system disorders, and other organ system failures that contribute to their suffering and premature death.

Medical management of this disorder has been unsuccessful. The mainstays of these treatment programs have been low calorie diets combined with pharmacotherapy, behavior modification, and the use of anorectics. Analysis of long-term follow up of patients on these programs reveals little change in weight from initiation of therapy, no reduction in predicted morbid or fatal events, and no improvement in medical, social, and functional disabilities. The

**‘I salute Dr. and Mrs. Headley not only for their career-long commitment to the care and follow up of these patients but also for their objectivity in recording and interpreting their results and their ability to adapt to and develop safer and more effective surgery.’<sup>1</sup>**

medical treatment programs are not without risks, as there have been fatalities associated with the low protein diets and the pharmacotherapy with thyroid hormones, diuretics, and anorectics.

**T**he malignant nature of this disease and its intractability to medical management have led to the development of surgical management. In this issue of the *Journal*, William Headley, M.D., and Mrs. Joyce Headley, R.N., describe their 22-year experience with the surgical management of

morbid obesity. They provide a critical review of the development and results of surgical procedures, describing the evolution from intestinal bypass procedures to the present state of the art of gastroplasty. Their long-term data on weight loss, improvement in hypertension, diabetes, gonadal dysfunction, and functional capabilities document the success of their treatment program. They stress that this success relies on the proper selection of patients, the right operation, a trained bariatric surgeon, and the postoperative and long-term follow up by an interested and knowledgeable team of physicians, nutritionists, and nurses. One of the reasons surgical treatment has been looked upon unfavorably in the past is that it was done without proper attention to all of these very important factors.

I salute Dr. and Mrs. Headley not only for their career-long commitment to the care and follow up of these patients but also for their objectivity in recording and interpreting their results and their ability to adapt to and develop safer and more effective surgery. Their recorded experience and recommendations will help us all in the management of patients with this difficult disease. ■

Dr. Rosenbloom specializes in endocrinology and internal medicine. Send reprint requests to him at 833 Campbell Hill St., Ste. 410, Marietta, GA 30090.



## Midnight in Chicago — The King's Physician

*The world is now too dangerous for anything but truth, too small for anything but brotherhood.*

A. POWELL DAVIES

IT HAD BEEN a pleasant evening, that which followed the annual gathering of a major third party payor. This gathering was designed to take stock of its state of health, to reassess its goals. The customary reception was followed by dinner. And then the quiet of late evening conversation with friends. We talked of many things — of children and grandchildren, of successes and failures.

But then our talk turned more serious. We had been all day in the meeting of this Goliath of the pre-payment world of health care and had talked of many concerns of the day: of government restraints upon expenditures; of the plateauing of "days per one thousand" of hospital stay and the impact of that on the "fiscal agent"; of the escalation, now out of control and not capable of analysis, of the physician component of the health care dollar; of the cycles so inexplicably a part of the financing of health care.

My friend said to me, "Is it fair or proper or reasonable that an anesthesiologist makes \$400,000 a year or an ophthalmologist \$800,000? Is it right that a cardiac surgeon generates an annual income of \$2 million? Is it

reasonable or right?"

I thought of the mortgage on my father's home, there at his death, which provided the medical school education. I thought of the years of college, of medical school, of training, and of slow ascendancy to professional success when at long last the father's mortgage, the borrowed money, could be repaid. I thought of the children, now grown to adulthood, with but few memories of a father save one constantly away. I thought of a wife too often left alone. I thought of the lives of professional friends too often shortened by the demands of the "great profession." I thought of the unconscionable extraction of monies from awards to the plaintiff by lawyers. I thought of professional athletes and entertainers.

And I said, "No. But let's be a part of the solution. Let's help you find the answer. If there are 'bad doctors,' let's help you ferret them out. If there are inequities, let's help you find them. We are your friends."

I felt well. A flash of pride, of magnanimity, rushed over me. I was convinced that we of organized medicine could help, could guide. Surely we of the House of Medicine could lead the way. Had we not for so many years? Had not the hospital administrators, the Boards of Trustees, the third party payors, even the governmental agencies come to our House for advice, to seek solu-

tions? Had we not been King of the Mountain?

"No," he said. "It's a new ball game, in a new and different playing field. You stand alone now, alone and with no allies, save us and those who yet trust you: we and your patients. One does not play the game today," he went on to say, "as dictator or controller. One plays as an equal partner with his or her fellow players. We are beyond that day when physicians can, with only self interest or self-generated concern, set the price of health care; beyond the day when hospital stays are determined in a decision-making process involving only patient and physician; beyond the day when the outcome of treatment, the quality, is an issue of low priority and then as judged only by the unregulated and poorly monitored physician community. We are now living in a world in which your charges, your quality, and your professional competence are a matter of concern and judged not only by your peers but also by those who purchase and receive your services — the consumers of health care.

We have wandered down a long and arduous road, we who were called to the practice of medicine — from Hippocrates under the olive tree, from leeches, incantations, herbs, and unctions through Alexis Carrell, who taught us the means whereby blood vessels might be joined together in those days before the million dollar cardiovascular surgeon to the plateau we have reached today. We were once the

"King's Physician," awaiting his beck and call, suffering our future as he saw fit to design it. We risked losing our reputations, if not our heads, over the unpredictability of our therapeutic prowess. We have come to this high plateau from which we can see more clearly our rightful place in the scheme of the profession to which we were called.

We are yet the "King's Physician." None can displace us save we ourselves. No more, if ever we were, the "King," That fact we must

come to grips with. Much more are we than this part; we are part of a greater whole. The controls, the reviews, the sanctions, the financial constraints — they cannot diminish us. Only recalcitrant obstinacy can. We are, indeed, the "King's Physician" but not islands unto ourselves. John Donne understood this when he wrote:

*No man is an island, entire of itself; every man is a piece of the continent, a part of the*

*main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or if thine own were; any man's death diminishes me, because I am involved in mankind; and therefore, never send to know for whom the bell tolls; it tolls for thee.*

JOHN DONNE, *Devotions XVII*,  
1623-24

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## Medicaid Expansion Appears Likely

Despite hospitals' efforts to promote improvements in Medicaid coverage in Georgia, sources at the governor's office have indicated that the governor will not recommend to the Georgia General Assembly any of the fiscal year 1990 budget requests of the Department of Medical Assistance (DMA) for Medicaid improvement.

Thus, there will likely be no recommendation for any of the following:

- No recommendation to expand Medicaid eligibility;
- No recommendation for a swing bed program for small rural hospitals;
- No recommendation for preadmission review, which would end the cap on hospitals' Medicaid admissions;
- No recommendation for revisions in the outlier payment methodology;
- No recommendation to restore the full intensity factor for disproportionate share hospitals;
- No recommendation for a rate increase in hospitals' Medicaid reimbursement. If the legislature accepts this provision, hospitals' Medicaid rates will continue to be based on the 1987 cost report, and the Georgia Hospital Association estimates that the result will be a 10 to 15% cut in hospitals' Medicaid reimbursement for 1990.

The denial of the DMA's requests is part of an effort to put the state budget within the revenues expected from current taxes. Estimates are that the continuation of the present Medicaid program and expansions in the state employee health plans will cost \$148 million and \$75 million, respectively, and those items together will make up slightly

more than half of the \$438 million available for improvements in FY 1990.

On the agenda of recommendations, however, is a \$.06 motor fuel tax to fund highway development. Revenues from that tax would take highway projects out of the general fund and release \$100 million for other programs. The governor will recommend that the entire \$100 million be committed to improvements in quality basic education.

## Hospitals Continue their Fight to Save Medicare

In a continuation of 1988's efforts to protect Medicare reimbursement, hospitals throughout the country have begun a new American Hospital Association-sponsored campaign, "Resolve to Protect Medicare."

The goal of the new program is to generate signatures from hospital personnel as well as from the general public on petitions asking Congress to put an end to Medicare reimbursement cuts.

The petitions, which AHA has sent to its member hospitals, were presented to Congress during the national association's annual meeting in Washington, DC, January 31. Hospitals planned to present to each member of Congress a petition from his or her district.

## OBRA Restricts Nursing Home Admissions

Hospitals are seeing some far-reaching effects of the Omnibus Budget Reconciliation Act (OBRA) of 1987 in severe restrictions on nursing home admissions.

Under the provisions of OBRA, effective January 1, a mentally ill or retarded patient cannot be admitted to a nursing home unless that patient requires the

24-hour physical care that a nursing home provides.

Though that portion of the law was brought about by advocates for the rights of mental patients, the outcome has backfired on the advocacy groups. According to the Georgia Hospital Association, the result will be that many mental patients won't be able to find any type of care at all. In Georgia, an estimated 3,600 patients will be denied nursing home admission.

Under the provisions of the law, every patient bound for a nursing home must now be reviewed to determine whether that patient is mentally ill or retarded. Original plans were that the review could only be carried out by state officials; however, as a result of the hospital association's intervention, hospital personnel will now be able to assist in the review and hopefully eliminate the potential admission delays the total state review could create.

## Taking a Second Look at Hospital Costs

Refuting allegations that hospitals are at fault for the continued rise in health care costs, the American Hospital Association (AHA) has released data showing that hospital expenses have remained flat since 1982 — 4.3% of the gross national product.

In addition, the AHA points out that hospitals' Medicare payments have been on the decline for the past 9 years. In 1980, a total of 73% of all Medicare payments went to hospitals; yet in 1988, only 65% of Medicare payments were hospital payments.

The public, says the AHA, needs to reexamine its preoccupation with regulating hospitals, because hospitals are not consuming an ever-increasing share of national resources.



## FEBRUARY 1989

10-11 — *Augusta: Flexible Fiberoptic Sigmoidoscopy.* AMA Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

11-18 — *Copper Mountain, CO: New Horizons in Anesthesiology.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

18-22 — *St. Thomas, Virgin Islands: Clinical Problems in Gynecologic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

20-24 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MARCH 1989

2-9 — *Keystone, CO: Snow Job in Gynecology & Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-4 — *Atlanta: 26th Annual Emory/Grady Post-Graduate Ophthalmology Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-4 — *Atlanta: Pediatric Orthopaedic Seminar.* Category 1 credit. Contact Darlene Baugus, CME Ed. Coord., Ed.

Dept., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/257-2148.

3-5 — *Sea Island: Georgia Chapter, American College of Surgeons.* Category 1 credit. Contact Ellis Keener, M.D., 434 Academy St., Gainesville 30505. PH: 404/523-3401.

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-11 — *Augusta: 24th Annual Family Practice Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-11 — *Sea Island: Critical Care at the Cloister.* Category 1 credit. Contact Mercer Univ. Sch. of Med., Office of CME, Macon 31208. PH: 912/744-1634.

10-11 — *Atlanta: Cancer Care in Community Hospitals IV: "Cancer Care — Who Pays, How Much?"* Category 1 credit. Contact Linda Scheiveland, Dir. of Education, Ga. Div., Am. Cancer Society, Atlanta 30322. PH: 404/892-0026.

15-17 — *Atlanta: The Drug Abuse Challenge to the Black Communities Health* (Sponsored by the Cork Institute on Black Alcohol and other Drug Abuse). Category 1 credit. Contact Andriette Ward, Office of CME, Morehouse Sch. of Med., 720 Westview Dr., Atlanta 30310. PH: 404/752-1770.

29-Apr 1 — *Pine Mountain: Eighth Annual Geriatrics Conference.* AMA Category 1 credit and AAFP Prescribed Credits. Contact Helen Peterson, 710 Center St., Columbus. PH: 404/571-1145.

29-Apr 2 — *Tucson, AZ: Eleventh Annual Pediatric Postgraduate Course, Pediatrics in Review, "Birth to Adolescence."* Category 1 credit, PREP credits, & prescribed AAFP. Contact Janice Cavanaugh or Darlene Baugus, Education Dept., Scottish Rite Children's Hospital, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/257-2148.

30-Apr 1 — *Atlanta: Technical Innovations in Neoplastic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 3322. PH: 404/727-5695.

## APRIL 1989

3-7 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-7 — *Atlanta: Modern Methods of Diagnosing & Treating Diabetes Mellitus & Its Complications.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14 — *Atlanta: Hepatic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

16-20 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXI.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



# Evolution and Current Status of Surgery for Morbid Obesity: Part I

## Results of Over 1400 Surgical Procedures Spanning 22 Years

William M. Headley, M.D., F.A.C.S, Joyce C. Headley, R.N., P.A.

*Editorial Comment: This issue of the Journal brings to you the first of a two part presentation of a paper dealing with the problem of Morbid Obesity. It is a condition afflicting the human body thought by some to represent a metabolic variance from the norm and by others a derangement of one's emotional milieu. By still others, it appears to be more clearly a social matter arising from the environment of the fiscally impoverished. Regardless of cause, the morbidly obese reside among us as a problem with both medical and social mandates.*

*The principal author, Dr. William Headley, carries on a private practice of surgery in Milledgeville, Georgia. He has for many years been interested in the problem of the morbidly obese and his experience with that problem is broad. His paper is a major contribution to this area of medicine and surgery. It is because of the elusive nature of the subject matter and the*

*various solutions proposed for it, as well as the basic scientific worthiness of the effort and the reporting of that effort, that your Editor asked that the paper be reviewed by two surgeons interested in and conversant with the problem. Also, that another of similar interest write a critique. It is our opinion that this paper warrants your careful attention and considered judgment as to how the private practitioner, without firm university connections, can conceive, carry out, and report their efforts with a particular medical or surgical problem. Part II will appear in the March issue of the Journal.*

Charles R. Underwood, M.D.

Dr. Headley specializes in general and bariatric surgery; Ms. Headley specializes in bariatric surgery. Both are affiliated with the Baldwin County Hospital in Milledgeville. Send reprint requests to Dr. Headley at P.O. Box 656, Milledgeville, GA 31061.

### Introduction

**M**ORE THAN 20,000 surgical procedures for morbid obesity are done in the United States each year. Yet many physicians are not well informed about the important place of surgery in the management of morbid obesity or about the evolution of surgical procedures for weight reduction over the past 3 decades. Since the introduction of the intestinal bypass in the early 1950s,<sup>1</sup> more rational and sophisticated procedures of proven efficacy and safety for the relief of persons who are 100 pounds or more over ideal weight have been developed.

Most physicians, whether internists or surgeons, will encounter morbidly obese patients in their practice. A 1974 survey found 2.8 million American men (5%) and 4.5 million women (7%) to be "severely obese."<sup>2</sup> It is commonly believed that these are gross underestimates of extreme obesity, and that as many as 15 million people in the U.S. may be severely obese.

Obese persons have a disproportionately high incidence of illness. It would be of benefit to both physicians and their patients for physicians to have a greater familiarity with the medical problem of morbid obesity and the various medical and surgical approaches to treating it.

This article reviews our current knowledge of the incidence and

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**This article reviews our current knowledge of the incidence and causes of extreme obesity, its medical consequences, and the great difficulty of treating obesity with diet and behavior modification.**

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causes of extreme obesity, its medical consequences, and the great difficulty of treating obesity with diet and behavior modification. The major surgical procedures that have been used to produce weight loss in this population are described, their complications compared, and long-term results evaluated. A few guidelines are provided for the primary care physician who takes care of patients who have had bariatric surgery. Throughout this review, we will draw on our experience at the Baldwin County Hospital in Milledgeville, Georgia. Since 1966, more than 1400 bariatric surgical procedures have been done. Our results with the various weight reduction operations will be summarized.

The major points that will be made are these:

1. Morbid obesity is a serious health problem.
2. Nonsurgical means of weight reduction rarely produce significant long-term weight loss in severely obese persons.
3. Surgical procedures with a minimum of complications can pro-

duce loss of more than 60 percent of excess weight in a large majority of morbidly obese persons.

4. This weight loss persists in follow ups of 5 to 10 years and longer.
5. Weight loss following bariatric surgery results in improvement in associated medical conditions, in addition to improvement in quality of life and psychologic status.
6. The bariatric surgical procedure which is currently considered to provide the optimum combination of safety and weight loss is the vertical banded gastroplasty.

More extensive treatments of bariatric surgery are available.<sup>3,4</sup>

### **Morbid Obesity**

Morbid obesity is defined as being at least 100 pounds over ideal weight.<sup>5,6</sup> Generally accepted tables listing weight standards by gender and height were published in 1959<sup>7</sup> and revised in 1983.<sup>8</sup> The 1983 standards are more liberal in listing approximately 12 percent higher average standard weight for shorter males and all females. In 1986, the American Society of Bariatric Surgery adopted the 1983 tables for the purpose of patient eligibility for bariatric procedures.

Bariatric surgery is generally confined to persons who are morbidly obese, as defined above. This arbitrary cutline leads to a dilemma of obesity surgery: Some patients who do not meet this criterion deliberately gain weight to become eligible. Many patients reach the point where they realize that surgery is their only hope of weight loss well before they meet the strict definition of morbid obesity.

Studies of the health status of obese persons show that excess weight predisposes to increased illness and early death. Excess mortality occurs at weights as low as 20 percent over average. Persons who carry 50 percent excess weight have excess mortality ranging between 75 percent and 115 percent. Excess mortality increases steeply with further increases in excess weight. Drenick and colleagues<sup>9</sup> found a 12-fold excess mortality

among morbidly obese men between the age of 25-34 years compared to men of the same age group in the general population. Among obese men 35-44 years of age, there was a 6-fold excess mortality.

These authors suggested that previous studies had underestimated excess mortality from morbid obesity. An extensive analysis by Manson, et al.<sup>10</sup> supports this contention.

In addition to having a high probability of early death, severely obese persons have an increased incidence of numerous diseases. These include coronary heart disease and sudden death, hypertension, diabetes mellitus, gallbladder disease, endocrine disorders, thromboembolic disease, osteoarthritis, cardiorespiratory dysfunction, sleep apnea, and skin conditions.<sup>11-13</sup> An increased risk of cancer has also been found in morbidly obese persons, with women having 57 percent excess rate of cancer and men a 35 percent increase.<sup>14,15</sup> Most notably, markedly obese women had a 5.4 times higher risk for endometrial cancer than nonobese women.

**I**t has long been assumed by most people that extreme obesity is a reflection of underlying psychopathology. Rigorous psychologic studies have demonstrated that this is not the case.<sup>16,17</sup> According to Halmi, et al.<sup>17</sup> strictly defined major psychopathology appeared to be no higher among candidates for bariatric surgery than among a standard control population. Several similar studies have been reviewed by Stunkard.<sup>18</sup> These studies have found that the psychologic abnormalities that occur among extremely obese persons, such as disturbance of body image, are often realistic for their condition.

At the present time, no single, cogent explanation for severe obesity is available. However, the prevailing view is shifting from the perception that obesity represents a weakness of will to that of obesity as a derangement of physiology. Clinical research supports the existence of genetic and physiologic components to obesity.<sup>19,20</sup> Recent data indicate that many people become obese more because of a low



metabolic rate than because they eat too much.<sup>21,22</sup>

One example of the physiologically based hypothesis for morbid obesity is the *setpoint* theory, which postulates that each person's body adjusts its metabolic rate to maintain a certain weight, possibly through hypothalamic regulation.<sup>23,24</sup> Obesity can be explained by a setpoint that results in a high body mass. It is possible that the setpoint is adjusted upward as one gains weight, whether it can be readjusted downward is not clear.

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## **Explaining obesity as the result of disordered physiologic regulation makes it easier to understand why dieting and other nonsurgical techniques have little or no success in producing long-term weight loss among obese persons.**

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Circulating factors, including beta-endorphin, have been found to be altered in experimentally obese animals.<sup>25</sup> Some researchers hypothesize that a deficiency of the brain neurotransmitter serotonin produces an insatiable craving for carbohydrates.

Based on our clinical observations, we agree that there is a strong biologic component to obesity. We have noted a tremendous similarity between alcoholics, drug addicts, and patients with morbid obesity, suggesting a form of addiction to food among the severely obese.

Explaining obesity as the result of disordered physiologic regulation makes it easier to understand why dieting and other nonsurgical techniques have little or no success in producing long-term weight loss among obese persons. Our experience is the same as that of other bariatric surgeons: Patients who come to us for weight-reduction surgery have already tried, without

lasting success, countless diets, diet pills, behavior modification, jaw wiring, injections of various types, hypnosis, ear stapling, acupuncture, and more recently, the gastric bubble. All these approaches have the same problem: Early weight loss is regained within a year or 2.

In a few rigorously conducted and medically supervised programs, dietary weight-loss regimens have been temporarily successful. Drenick and Johnson<sup>26</sup> followed 1212 morbidly obese men for 7 years after in-hospital fasting and subsequent semistarvation. On average, the men lost 41 kg (90 lb.). By two years, they had begun gradually to regain the lost weight, and at 7 years, only seven (6%) men had maintained weight loss.

Protein-sparing supplemented fasting, plus behavior modification and exercise, was tried by Blackburn<sup>27</sup> and Bristrian.<sup>28</sup> Seventy-five percent of their subjects lost at least 18 kg (40 lb.); but by 2 years, 70 percent of those losing weight had gained it back. Similar results were reported by Genuth.<sup>29</sup> Further data are not yet available.

In addition to the fact that weight loss on restrictive diets is temporary, very-low-calorie diets are potentially lethal unless supervised by an experienced physician. At least 58 persons died during a fad of liquid-protein dieting in 1977-1978 from ventricular arrhythmias possibly brought on by protein-calorie malnutrition.<sup>30,31</sup>

Jaw wiring has not been as extensively studied, but one scientific report on 14 subjects is available.<sup>32</sup> Fixation was maintained for between 4 and 20 months, for an average weight loss of 30 kg (68 lb.). Only one person maintained the weight loss for 2 years. In a review of surgical methods for weight reduction,<sup>33</sup> the judgment on jaw wiring, based on published studies, was that it produced weight loss, but that all subjects regain lost weight in a relatively short time.

Similar considerations apply to the gastric bubble or stomach balloon. The most optimistic results were obtained by Garren and Garren<sup>34</sup> who designed the bubble. Their data covers 6 and 10-month periods. During 6 months of implantation in 100 morbidly obese

persons, the bubble, combined with behavioral modification and dietary counseling, produced a mean weight loss of 18 kg (40 lb.). Over 10 months, the mean weight loss was 35 kg (77 lb.).

There are four major caveats to these findings. First, the Food and Drug Administration approved implantation of the bubble for 4 months, but later this was reduced to 3 months, because some patients experienced gastritis or deflation of the balloon followed by obstruction.<sup>35</sup>

Second, there are as yet no conclusive data to show that the bubble contributes significantly to weight loss. One study published in November, 1987, found no significant weight loss among patients receiving the balloon compared to those receiving sham procedures.<sup>36</sup>

Third, the Garren study is the most favorable outcome reported to date. Other trials have found much smaller weight losses and greater complication rates.

Fourth, and most important, there are no follow-up data showing that weight loss can be maintained once the bubble is removed. Again, as in almost all of the non-surgical methods, the problem is not losing weight as many of the techniques result in weight loss, but the maintenance of weight loss.

In sum, the value of the gastric bubble for long-term weight loss appears extremely limited.

### **Attitudinal Considerations Affecting Bariatric Surgery**

Because of the eventual regain of weight lost through dieting, jaw wiring, and other measures, surgery represents an attractive alternative for the treatment of morbid obesity. Indeed, for the morbidly obese, surgery offers the only high-probability hope of substantial long-term weight loss. Yet several psychologic factors can limit the optimal benefit from weight reduction surgery.

One inhibiting factor has been a slow acceptance of surgical procedures for weight loss within the medical community. Although difficult to document scientifically, it has been the impression of those of us who perform surgery for morbid obesity that other physicians



have regarded bariatric surgery with disapproval. This attitude seems to stem from the prevailing view that obese persons simply lack willpower and could lose weight "if they really wanted to."

Other factors possibly contributing to the negative attitude toward bariatric surgery are that weight loss is uncommon and unpredictable and that regain of lost weight is the typical outcome. We shall present data refuting these notions in a later section.

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Equally difficult to document is the impression that such prejudicial views are now decreasing among physicians. One bariatric surgeon estimated recently that 4 years ago only 10 percent of his practice came from referrals from other physicians, whereas more than 50 percent of his referrals now come from medical colleagues.<sup>37</sup> In our practice, a similar change has become evident over the last 5 years.

One likely factor in this shift was the National Institutes of Health's Consensus Conference on obesity held in March, 1985, at which the adverse effects of obesity on health and longevity were highlighted. Another influence may be an increasing favorable experience with obesity surgery as newer procedures supplant the intestinal bypass.

**A**n equally damaging misapprehension is the view that bariatric surgery can be performed by any skilled surgeon without special

training. The reality is that surgery for morbid obesity is specialty surgery and requires special training and instruments. Morbidly obese patients need special handling. For instance, a patient greater than 300 pounds may not fit into a CAT scanner. Morbidly obese patients may have a more difficult postoperative course and are more difficult to mobilize. They have a greater risk of pulmonary embolus or deep vein thrombosis, so special attention is required to decrease the incidence of these problems. Postoperative complications in morbidly obese patients can be more disastrous, so early recognition and surgical intervention are more important than in other patients.

The liability problems have certainly brought on increasing difficulties in dealing with patients over the last few years. Having reviewed a number of liability cases, it is my impression that the most frequent cause of a liability suit has been the inexperience of the surgeon. Some inexperience is the result of inadequate training, but in other cases a surgeon with some training in bariatric procedures may only perform such an operation occasionally. As with other specialty surgery, a practitioner needs to do a minimum number of cases per month to maintain his or her skills.

**A** third psychologic factor necessary to achieve the optimal benefit from bariatric surgery is to select appropriate candidates. In our practice, we find choosing the right patients to be one of the most difficult tasks. An important criterion is the patient's reaction to the discussion of surgical risk. Those persons who are surprised or upset by the prospect of surgical risks should be encouraged to return home and reevaluate their desire to have the surgery.

One of the best patient-related predictors of weight loss following surgery is the patient's response to the question, "Do you think there is any other treatment available that will help you lose weight aside from surgery?" Persons who answer "Yes," "Possibly," or "I'm not sure" should be encouraged to go home and try other methods of weight loss until they are certain in their own

minds that there is no effective alternative to surgery for them. Patients who have not tried an adequate number of weight-loss options might be tempted after a surgical procedure to believe that they have learned so much about eating that they can maintain their weight loss without the operation and ask to have it reversed. This has happened with several of our patients, with almost immediate weight gain to the presurgical level.

The best patients to manage are those who have thought out the details, are prepared, and seem to know what they want. We believe that it is a good sign if the patient arrives for the interview with a list of questions.

We have occasional failures in patient selection. One man told us postoperatively that he had figured out how to beat the gastroplasty operation by frequent eating of candy. A few patients have asked that their operation be taken down because they wanted to go back to their prior eating pattern. But with careful patient evaluation, patient selection can be more than 95 percent successful.

**P**sychologic preparation for surgery is begun prior to the initial office interview. When a patient calls to schedule an office evaluation, an information package is sent to the patient. This, in detail, informs the patient and his or her family about the surgery and indications for it. The educational and psychologic preparation is continued at the office where a videotape again details the indications, types of operations, possible morbidity and mortality, and what the expected outcome of the surgery might be, based on information from our patient database.

The videotape warns patients that they must cooperate with the operation for successful weight loss. It is estimated that the operation does about 80 percent of the work, but the patient must contribute about 20 percent of the effort by not eating sweets, refraining from frequent snacking, and refraining from drinking with their meals, as this has a tendency to wash out the pouch and reduce the sense of fullness.



Following the videotape, we meet with the patient and family. This interview is sound recorded and a copy of the tape is given to the family; one is kept for medicolegal purposes.

Additional videotapes are shown several times each day in the hospital via closed-circuit television. These tapes present further information that can be helpful both preoperatively and postoperatively.

### Bariatric Surgical Operations

#### Jejunioleal Bypass (JIB)

Intestinal bypass procedures were independently attempted by several surgeons in the early 1950s. These procedures were suggested by the drastic weight loss due to poor nitrogen absorption that occurred after extensive bowel resection for cancer or mesenteric artery thrombosis.<sup>38</sup> Due to the experimental nature of the operations, these innovators proceeded cautiously, and their experience accumulated slowly.

One of the earliest versions of intestinal bypass was the jejunocolic procedure, in which the ileum was anastomosed directly to the colon. Our first operation for morbid obesity was in 1966 and was of this type. It was done on a 300-pound man who had hypertension and elevated cholesterol and was badly disabled by his obesity. The resulting drop in weight reduced his blood pressure, but he had such severe diarrhea and uncontrolled weight loss that we converted his operation to an end-to-side jejunioleal bypass. The jejunocolic operation was soon abandoned.

The end-to-side jejunioleal bypass was patterned on the Payne procedure<sup>39</sup> in which the proximal 14 inches of jejunum was anastomosed to the side of the ileum 4 inches from the ileocecal junction. With this procedure, some patients had reflux of food back up the intestine and regained much of the lost weight. In 1971, after nine patients, we stopped doing this procedure in favor of the end-to-end jejunioleal bypass.

End-to-end jejunioleal bypass was reported in 1971 by both Salmon<sup>40</sup> and Scott.<sup>41</sup> The distal end of the bypassed segment of small intes-

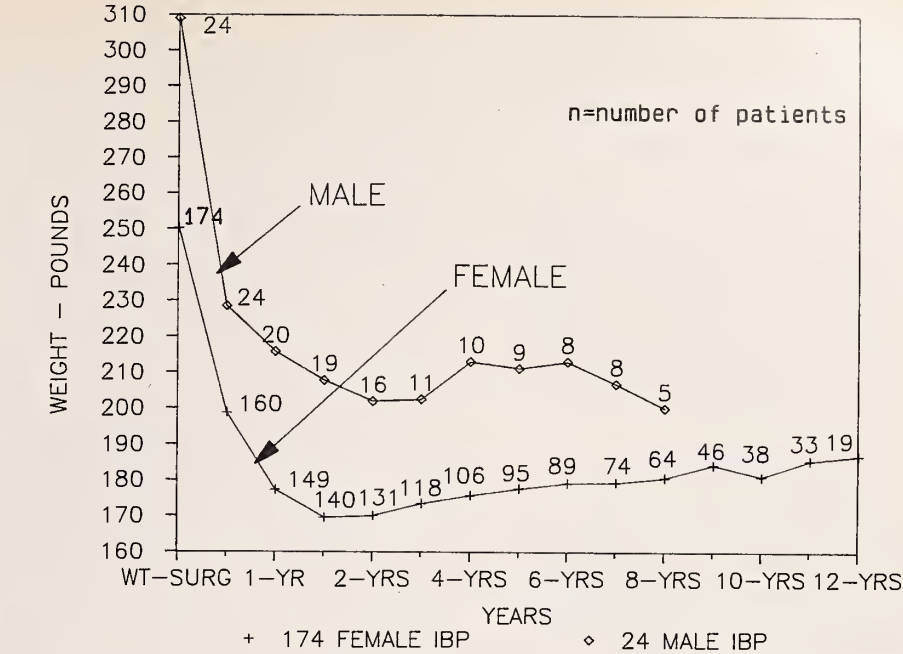


Figure 1: Results of weight loss from 198 Jejunioleal Bypass procedures, by sex.

tine was anastomosed to the colon, and the proximal end was closed. This technique became the procedure of choice for many surgeons.

Intestinal bypass is an intentional partial malabsorptive procedure. Patients can eat as much as they want, but much of the food passes through the intestinal tract partially digested.

Weight loss with jejunioleal bypass (JIB) was quite satisfactory in most cases. In our series of 198 intestinal bypass patients, there was an average weight loss of about two-thirds of excess weight during the first year (Figure 1). Follow-up studies show that this level of weight loss has been fairly well maintained for at least 12 years in most patients. Operative mortality with the JIB has been low. In our series, there were no deaths.

Unfortunately, some JIB patients have extensive long-term complications.<sup>42</sup> These include migratory arthritis; malabsorption of protein, calcium, magnesium and vitamins; enteritis and liver disorders in up to 20 percent of patients; kidney stones; stomal ulcer; and rectal problems from the acid content of the stools. As a result, after 12 years, about one-third of our JIB patients have had medical problems severe enough to require taking down their

intestinal bypass; one-third have some medical problems and require close attention, some of whom may need to have conversion to a stomach stapling procedure in the future; and one-third are doing well but still need to be followed closely.

Migratory arthritis occurs in about 20 percent of JIB patients and appears to be due to bacteria growing in the bypassed section of intestine because of the absence of acid. This arthritis clears immediately when the blind loop is taken down. It may be an immune reaction.<sup>43</sup>

Because of the anorectal problems such as proctitis, hemorrhoids, or anal strictures brought on by the acid diarrhea, some patients will need anal dilatation or partial sphincterotomy at the time of conversion of their JIB.

Some patients with the JIB had persistent severe diarrhea, but surprisingly that was seldom a major medical problem. These patients produce foul-smelling stools and flatus. The offensive odor is caused by the partially broken-down fatty acids, the same compounds found in rancid foods. Many have trouble with their marriages and social life because of this odor.

Currently, very few surgeons are performing the JIB. As Mason put it, "In spite of the fact that in-



testinal bypass is a technically easy operation that appeals to surgeons, there seems to be no way to make it safe without losing its effectiveness in weight control."<sup>44</sup>

Scopinaro attempted to correct some of the flaws of the JIB with the biliopancreaticojejunal bypass, including partial gastrectomy.<sup>45</sup> But he produced an extensive operation that takes 3 hours to perform. It avoids some metabolic problems but creates others.

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### **As with intestinal bypass, gastric bypass was patterned after an existing procedure, in this case gastric resection for peptic disease.**

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The phasing out of JIB has also been contrary to some patients' preference: "Patients favor intestinal bypass procedures because the preoperative high-calorie, high-volume intake can be continued. . . . Gastric restrictive operations are far safer, but they require behavior modification by the patient."<sup>46</sup>

#### *Gastric Bypass (GBP)*

Due to increasing dissatisfaction with the JIB, gastric partitioning procedures arose in the late 1960s.<sup>47</sup> As with intestinal bypass, gastric bypass was patterned after an existing procedure, in this case gastric resection for peptic disease. Many patients failed to regain their preoperative weight after a gastric resection. Indeed, many patients lost considerable weight after this procedure, which was considered a complication of the operation. This weight loss and maintenance of the weight loss, however, is exactly what the bariatric surgeon was looking for, and it became the main advantage of the gastric bypass procedure.

Unlike intestinal bypass, gastric bypass is not a malabsorption procedure; it is a calorie-restriction procedure. Gastric bypass eliminates the storage function of the stomach. Patients can only eat very

small amounts of food at a time. With the large storage portion of the stomach unavailable to food, afferent nerve signals to the satiety center of the brain that are triggered by gastric stretching occur with very small portions of food. This makes it difficult for patients to eat in their former manner, although very aggressive consumers can find ways to defeat or circumvent the gastric pouch.

Gastric bypass has gone through many variations. At first, the stomach was divided and a jejunal loop was anastomosed to the gastric pouch along the greater curvature. However, this approach was often complicated by problems of reflux gastritis and esophagitis. Later, the operation was made easier by using a continuous horizontal line of staples to create the fundic pouch, rather than doing a gastric resection.<sup>48</sup>

Currently, our technique for the GBP (Figure 2) is to form the pouch with a double row of staples. Bluett et al<sup>49</sup> contributed significantly to our understanding of the healing strength of the double staple line. The jejunum is divided 60 cm. from its origin. An end-to-side Roux-en-Y jejunojejunostomy is created with the proximal limb of jejunum. The distal end of the divided jejunum is anastomosed to the gastric pouch. This technique prevents reflux acid and bile gastritis and esophagitis.

The stomach pouch has been a problem in the past in that it would frequently dilate years after the surgery, allowing the patient to consume larger meals and thereby not maintain adequate weight loss. Over time, the pouch has been made progressively smaller, until now most of our pouches are between 10 and 30 cc's. The pouch itself is reinforced by suturing jejunum over 80 percent of the pouch surface, thereby decreasing the risk of gastric dilatation long after the operation.

One of the most important aspects of the GBP operation, learned through experience with several variants during the first 10 years that the procedure was used, is that *the gastric pouch must be made small for the operation to succeed*. These patients need to

have the reservoir function of the stomach markedly reduced. Initially, we created several-ounce pouches with a 12-15 mm. stoma (gastrojejunostomy), but this sometimes produced inadequate weight loss. We now make a 10-15 cc. gastric pouch (measured at 70 mm. water pressure), although any size up to 30 cc. appears to be effective. The side of the stoma is also important, with an 8-10 mm. opening being optimal in our experience.

Detailed weight loss results with the GBP will be presented below. In general weight loss is comparable to the intestinal bypass but with a lower short and long-term morbidity. Reversal of gastric bypass has been required in less than 1 percent of patients.

Metabolic problems common in JIB, such as migratory arthritis, are not a problem with GBP, because there is no blind segment of small intestine to allow bacterial overgrowth.

Stomal ulcer is uncommon after GBP. With the small gastric pouch, very little gastrin is produced, so very little acid is made by the parietal cells, either proximally in the gastric pouch or distally in the stomach.

The major complications of GBP surgery are those that occur in the immediate postoperative period, notably anastomotic leak or bleeding. When there is leakage or perforation, pain is often prominent. Pain occurring suddenly after surgery is often posterior or to the left shoulder. If the leakage drains to the pelvis, patients may complain of marked urinary urgency. Patients often become quite anxious and deep breathing can be very painful. Tachycardia greater than 120 beats per minute is another indicator of possible leakage or perforation. These symptoms are due to loss of a large amount of fluid in the peritoneal cavity and the irritating effect of the gastric juices on the peritoneum. If not managed expeditiously, the loss of intravascular volume will lead to profound shock. The key to recovery is early recognition and immediate reoperation.

Leakage in obese post-surgical patients has been misdiagnosed as pulmonary embolism, atelectasis, or pneumonia. Time is wasted pur-





*Figure 2 — The Gastric Bypass eliminates the storage function of the stomach.*

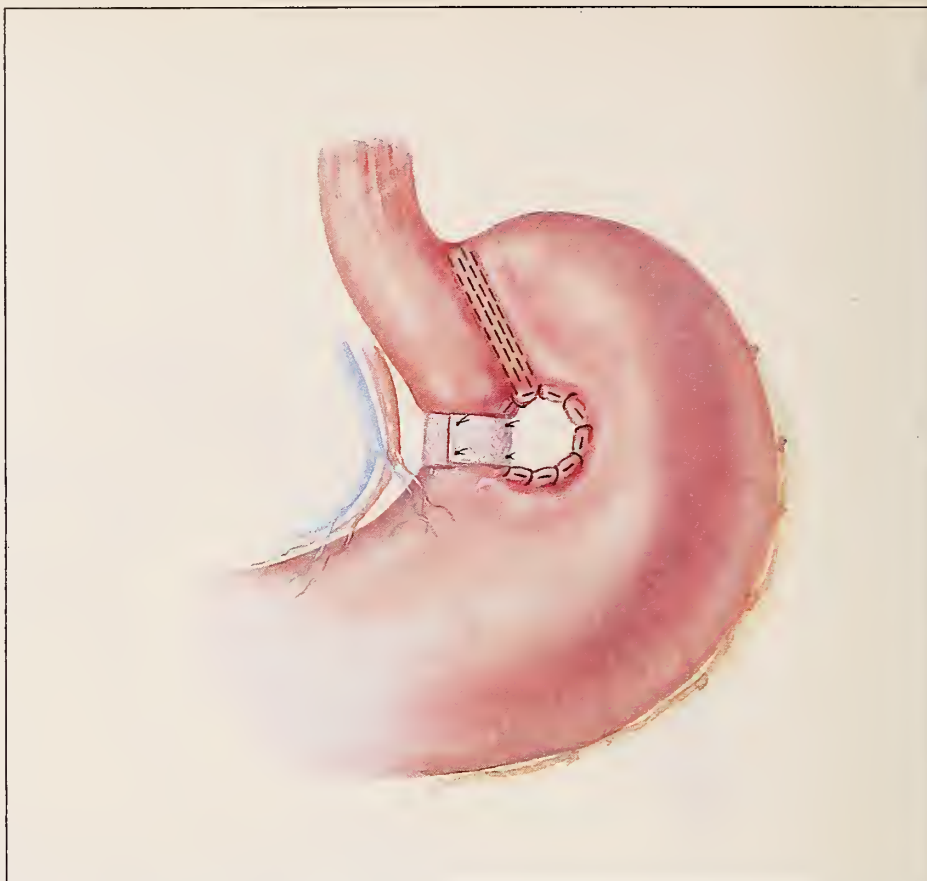
suings these diagnoses while the leak is producing a generalized peritonitis and its consequences. In the morbidly obese patient, it is safer in the postoperative period if there is suspicion that a leak or perforation may have occurred to explore the abdomen at an early stage. In the slender patient, one often has time to wait, further evaluate, and give fluids and antibiotics. In the morbidly obese patient, this time lost may result in mortality.

#### *Vertical Banded Gastroplasty (VBG).*

Vertical banded gastroplasty is probably the first surgical procedure to be designed specifically for weight loss, as opposed to being an adaptation of an existing procedure intended for another purpose. The VBG incorporates lessons we have learned from 3 decades of obesity surgery and is currently the culmination of the evolution of bariatric surgery. It provides an optimal combination of operative ease, desired weight reduction, and minimal side effects.

Experience with gastric bypass showed that there is a rationale for a surgical obesity procedure that allows food to pass through the duodenum. For example, iron, vitamin B<sub>12</sub>, and calcium malabsorption syndromes would occur less frequently in the VBG as compared to the GBP patient. Nonoperative diagnosis and treatment of problems of the distal stomach and duodenum are more difficult to treat in the GBP patient.

The first gastric pouches were formed horizontally. Unfortunately, a fundic pouch is not desirable for caloric restriction, since the greater curvature of the fundus is the most distensible part of the stomach. A procedure called the horizontal gastroplasty was done by placing a staple line across the upper portion of the stomach creating an upper small pouch and a much larger lower or distal pouch. Before the staples were placed, several of the staples were removed from the cartridge, thus allowing for an opening between the upper and lower pouch. Unfortunately, this led to a weak staple line with subsequent dilatation of the stoma and frank breakdown of the staple line.<sup>50</sup> This procedure is no longer done.



*Figure 3 — The Vertical Banded Gastroplasty is currently the most popular technique used for the surgical treatment of morbid obesity.*

The concept of a gastroplasty without a bypass was still a viable one, but it took a series of conceptual breakthroughs to arrive at the present vertical banded gastroplasty. Tretbar<sup>51</sup> was one of the first to use the vertical configuration. He formed an unreinforced 18 cm.-long vertical pouch along the entire length of the lesser curvature to the pylorus. Laws<sup>52</sup> added a ring of Silastic tubing held in place around the distal pouch opening (vertical ring gastroplasty).

**T**he vertical band gastroplasty (Figure 3), was first employed by Mason in 1980.<sup>53</sup> A major innovation was that the pouch outlet was reinforced with a 1.5-cm. wide Marlex collar to assure a constant stomal size. The collar was not sewn to the stomach wall but to itself. This is distinct from previous procedures, in which the outlet-reinforcing material was anchored to the lower end of the stapled partition, creating a risk of migration of the suture into the lumen. The mesh collar is quickly surrounded by connective tissue and forms a new outerlayer to the stomach wall. At

this time, the vertical banded gastroplasty is the most frequently used gastroplasty.

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**The first surgical procedure designed specifically for weight loss, the vertical banded gastroplasty incorporates lessons learned from 3 decades of obesity surgery and is currently the culmination of the evolution of bariatric surgery.**

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In practice, we construct a measured 10-15 ml. gastric pouch with a vertical staple line. As in the GBP, a small pouch is crucial. Mason has stressed the need to measure the pouch volume, so that various pro-



cedures can be compared more accurately. The Marlex mesh is adjusted to produce a 5 cm. circumference (10 mm. internal diameter) outlet. Our data (presented below) suggest that a 4.5 cm. circumference may be too restrictive and may lead to excessive snacking and high carbohydrate consumption. Direct visualization by endoscopy of the distal stomach and duodenum can be carried out with ease in the VBG patient.

Although experience with the VBG is less than with the JIB or GBP, it appears to be the most complication-free of all bariatric procedures so far. We have had a 0.2 percent perioperative mortality rate (one death) in over 525 consecutive cases. This compares with a 1 percent mortality rate in the GBP series of over 625 patients.

An alternative form of vertical gastropasty is the vertical ring gastropasty, in which the outlet of the pouch is reinforced with a Silastic ring. In one direct comparison study,<sup>54</sup> the two procedures were found to be equivalent except for a twofold greater incidence (19% vs. 9%) of stenotic complications with the ring gastropasty. But in a much larger series,<sup>55</sup> no erosion of uncovered silastic rings used to support the outlet of the gastric pouch was observed during a 5-year follow up. The reason for the difference in stenosis rates between these two studies is not clear.

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*(Note: The conclusion of this article will appear in the March, 1988, issue of the Journal. Part II will discuss how to choose the appropriate procedure for the individual patient based on outcomes from the authors' experience. Also, long-term follow up of the bariatric surgical patient will be discussed.)*

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# Diverse Systems, Common Ground: Impressions of the World Medical Assembly

Thomas Kinser

**L**ATE LAST SUMMER, a friend from the national Blue Cross and Blue Shield Association called to ask if I would prepare a paper, join the American Medical Association delegation, and attend a meeting of the World Medical Association (WMA) in Vienna. I would be the national Blue Cross and Blue Shield representative, and he would share the travel costs.

While honored, I responded cautiously. With little experience in international affairs, could I effectively represent Blue Cross and Blue Shield at such an important gathering? We discussed this a bit, and when he gave a slight suggestion that my self-deprecating remarks might be accurate rather than representing dignified modesty, I quickly accepted and congratulated him on his ability to recognize talent.

## The 40th World Medical Assembly

In September, 1988, my wife and I found ourselves in Vienna with an extraordinary group of physicians

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from the United States, Austria, Germany, Japan, Australia, and a host of other countries. It proved to be an astonishing personal and professional experience for this non-physician.

The WMA is an association of national medical associations that was formed in 1947 to discuss issues and problems common to physicians around the world. It is a voice for professional excellence and high ethical standards. Many issues dis-

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Mr. Kinser, president and chief executive officer of Blue Cross and Blue Shield of Georgia, attended the 40th World Medical Assembly in Vienna, Austria, Sept. 27-30, 1988. This article represents some of his impressions of that international conference.

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cussed and debated in the United States are dealt with around the world in a variety of social, political, geographic, and economic settings.

## Business Issues

Several interesting issues arose at the business portion of this international gathering. Dr. H. Lindsay Thompson of Australia was concluding his term as president. The new president is a most interesting individual — Dr. Enrique Huertas of the Cuban Medical Association Overseas. He has not been in Cuba for decades but resides and practices in Miami.

Dr. Huertas will be dealing with one issue born of the larger world of politics during his term: 10 important countries dropped out of the WMA when South Africa was accepted for membership. Negotiations are in progress to have them return to the fold.

Other issues: A number of policy statements were dealt with and discussed, including those on infant health, the use of tobacco prod-

ucts, professional responsibility for treating AIDS patients, group practice, and others. The statements are designed to be helpful in later debates with politicians in member countries.

The spirited debate over business issues involved a wider variety of languages but nonetheless resembled that of any hospital medical staff or the Medical Association of Georgia House of Delegates, with similar amounts of wisdom and nonsense.

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## **Relationships between physicians and nurses seem to be strained everywhere. . . . Professional turf issues seem endemic on all of the continents.**

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### **American Medical Association**

The American Medical Association was represented by Dr. James Sammons, executive vice president, and other key staff and board members. Clearly, the American group is a major power and respected in the organization. They worked hard, presented papers, asked questions, and proudly advocated an American point of view, without suggesting ours is the only way. It was a pleasure to be a guest of the delegation and to know this group of leaders.

### **Educational Meetings**

The business meeting was followed by 2 days of educational programs. The first was devoted to "Access to Health Care Under Various Medical Delivery Systems." The impact of diverse factors on access to care was reviewed by an assemblage of speakers. Factors discussed included geography, physician manpower, nursing manpower, cost, and payment systems — all from an extraordinary variety of points of view. Some points of interest:

- There is a consensus that there is a growing surplus of physicians in developed countries, while underdeveloped nations continue to experience a shortage. France has some 8,000 physicians who cannot find work, and the Philippines export 50% of their medical graduates. One panel member from Israel stated that her physician works as a hairdresser to earn extra money!
- Relationships between physicians and nurses seem to be strained everywhere. The discussions over the definition of a team and the role of its captain were familiar, albeit in other languages. Professional turf issues seem endemic on all of the continents.
- Concerning geographic limits on access, there were numerous reports of creative and successful responses. Innovative transportation methods, such as Australian flying doctors and outreach programs involving mobile doctors and nurses in remote African areas, were presented.
- Cost is a universal problem. Physicians from all over the world feel economics limit their ability to provide quality care.

### **Financing in the USA**

My talk, also part of the educational program, described the American financing system in its most basic form. It is difficult for the uninitiated to understand how we function without a universal insurance system. I explained our system of private carriers working primarily with employers to provide benefits in the private sector. I described the government programs — Medicare for the aged and Medicaid for the poor. And I acknowledged that while most Americans have good financial access, a group of uninsured does exist, which is a problem for the U.S.

I also spent some time discussing one of many major changes going on in our country: the fact that historic freedom-of-choice of physician and patient is under substantial pressure, as health maintenance organizations (HMOs), preferred provider organizations

(PPOs), and other managed-care systems try to cope with the problem of extraordinary cost increases.

My co-panelist, the president of the German Medical Society, and I then entertained questions. By coincidence, I was the first American speaker and the world's fascination with the United States became clear. For 20 minutes, every question was addressed to me. I heard from the Japanese, Turks, Dutch, Germans, Austrians, and others. Most were cordial and genuine. A couple seemed to offer critiques of American values rather than pose real questions. The physician leaders of the AMA leaped to support me and the national honor.

In all of the sessions on the first day, a couple of other general points became clear. Health financing and delivery systems vary widely around the world and adapt to individual cultural, geographic, and economic situations. In every case, government plays a major role, and doctors play a major role; there is a constant strain between them, fueled by financial and control issues. If any physician praised his or her government's health policy on funding levels, I missed it.

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## **In all countries, there is a constant strain between the government and the doctors, fueled by financial and control issues. If any physician praised his or her government's health policy on funding levels, I missed it.**

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A review of comparative data show huge and largely unexplained differences in efficiency, costs, and quality of care in the various countries. There seems to be a tendency toward individuals paying more, as government, business, and insurance fail to grow as fast as costs.



How to take care of the poor and the elderly was a persistent issue, as well as a lack of success at controlling the growing demand for more and more care.

### Group Practice

The second day of the educational program dealt with group practice. Dr. James Davis of the United States led a discussion on defining group practice and describing trends in the U.S. Speakers from Europe, Asia, South America, and Australia followed. Advantages and disadvantages of group practice were dispassionately reviewed. Group practice seems most prominent in North America, less so in Europe, and just emerging in other areas of the world.

By the end of the session, I concluded that group practice is a growing force all over the world and appeals to more and more physicians and patients. But it has the potential of infringing on professional autonomy in undesirable ways and should be watched carefully with these disadvantages in mind.

### Some Social Items

The social functions associated with the WMA were a source of much pleasure. Vienna has great charm and is easy to enjoy. Our Austrian hosts were most gracious. Meeting physicians and their wives from all over the world was a source of continuing interest and stimulation. One pleasant seatmate on the bus turned out to be the president of the Australian Medical Society. And talking to members of the large Japanese delegation made the emergence of the Pacific Basin countries more tangible and real than do the Toyotas and stereos we have at home.

### Conclusion

The conference reminded me again of how complex health care is and how difficult it is to change. It involves every human who ever gets sick along with the accompanying intense emotions. We are

dealing with thousands of hospitals, millions of doctors, billions of people, and trillions of dollars, pounds, rubles, yen, francs, marks, etc.

Every speaker focused on problems and issues in his or her country, and we saw once again that no country has ever solved the health-care equation. There is no *one* best way to finance and deliver medical care. Everyone talked openly about problems and things that do not work. The tensions we feel should be seen as inevitable and part of the creative drive that makes us evolve and get better.

My experience proves again that you need to travel to know your home. The American pluralistic system seems the best for us, and other countries with strong public and private sectors seem to be doing fairly well. The countries with monolithic government programs seem least effective and least happy, as well as underfunded and resistant to change.

I am glad my friend called.

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# Trends in Cause-specific Infant Mortality in Georgia

Charlotte M. Druschel, M.D., Brian J. McCarthy, M.D., Michael R. Lavoie, R. Keith Sikes, D.V.M.

## Introduction

**W**E PREVIOUSLY EXAMINED infant mortality rates for Georgia in three time periods, 1960, 1974-76, and 1980-82, to study the potential for future reduction (*JMAG*, January, 1989). We estimated the potential for reduction in infant mortality to be 7 per 1000 live births. Although 2.8 per 1000 of this potential is associated with interventions to prevent very low birthweight, a significant portion, 2.6 per 1000, could result from a reduction in the mortality of normal birthweight infants ( $>2500$  gms). In this article, we examine trends in cause-specific mortality in normal birthweight infants to determine where our success has been achieved and where gaps still remain.

## Methods

Neonatal and postneonatal mortality rates for black and white infants were compared for three time periods: 1960, 1974-76, and 1982. We calculated cause-specific mortality rates using linked birth death

## Abstract

**W**e previously reported that almost one third of the potential for reduction (PFR) in infant mortality in Georgia would result from reduction in mortality of normal birthweight infants. To determine where reductions were made in the past and where gaps remain, we examined trends from 1960 to 1980-82 in cause-specific mortality for normal birthweight infants by race.

In the neonatal period, mortality was reduced by 66% for white infants, 76% for black infants. In the postneonatal period, overall reductions were smaller than in the neonatal period, 50% for white and 71% for black infants. The majority of the remaining gap resulted from excess mortality in the infection, injury, and Sudden Infant Death categories.

The widest gaps in infant mortality exists in the postneonatal period. There is a 12% potential for reduction in the black infant mortality rate if interventions directed at the normal birthweight infant in the postneonatal period are emphasized.

files of live births to Georgia residents. For 1960, we used the Georgia births from the national birth-

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death linkage; for 1974-76 and 1980-82, we used the state's linked files. We used the 1960 definition of low birthweight,  $\leq 2500$  grams; thus, normal birthweight is  $>2500$  grams.

Each of the three time periods used different editions of the *International Classification of Diseases* (ICD) code: 1960, the 7th edition; 1974-76, the 8th; and 1980-82, the 9th.

The 7th edition is very limited in cause of death codes, especially perinatal conditions; there is no code for respiratory distress syndrome (RDS).

We designated as the cause of death the code listed as the underlying cause of death and grouped the codes into categories (Table 1). The final categories are different for the neonatal and postneonatal periods. In the neonatal period, there are eight categories: infections, congenital anomalies, RDS/immaturity, birth trauma/asphyxia, perinatal disorders, external causes, other systemic disorders, and signs.

**TABLE 1 — Cause-specific Neonatal Mortality Rates\*, By Race, Georgia Resident Births, Infants >2500 grams**

	1960	1974-76	1980-82	% Change
<b>Infection</b>				
White	0.6	0.3	0.2	-67%
Black	2.6	0.7	0.3	-88%
<b>Congenital Anomalies</b>				
White	1.7	1.0	0.8	-53%
Black	0.9	0.8	0.7	-22%
<b>Asphyxia</b>				
White	1.8	0.5	0.3	-83%
Black	2.4	0.9	0.4	-83%
<b>RDS/IMM</b>				
White	<0.1	0.4	0.1	-
Black	0.4	0.3	0.2	-50%
<b>Perinatal</b>				
White	0.7	0.2	0.1	-85%
Black	1.1	0.4	0.3	-72%
<b>External</b>				
White	<0.1	<0.1	0.1	-
Black	0.3	<0.1	0.1	-67%
<b>Systemic</b>				
White	0.4	0.2	0.2	-50%
Black	0.4	0.2	0.1	-75%
<b>Signs/SIDS</b>				
White	0.2	<0.1	0.1	-50%
Black	1.1	0	0.2	-82%
<b>Total</b>				
White	5.3	2.6	1.8	-66%
Black	9.3	3.6	2.2	-76%

\*Rate per 1,000 live births

RDS/immaturity are causes due to preterm birth or intrauterine growth retardation; birth trauma/asphyxia are injuries at time of delivery, intrauterine, or birth asphyxia. Perinatal disorders include metabolic, endocrine, and hematologic conditions specific to the perinatal period. External causes are deaths resulting from non-birth injuries or external agents. Other systemic disorders are deaths attributed to other specific diagnoses, such as neoplasms. Signs are conditions not clearly specified, such as volume depletion or cardiac arrest. Sudden Infant Death Syndrome (SIDS) in the neonatal period is included in the signs category.

In the postneonatal period, we used six categories: infection, congenital anomalies, external causes, SIDS, systemic disorders, and signs. The systemic disorders category additionally now includes the perinatal and RDS/immaturity categories, as the number of deaths due to these causes is very small.

## Results

### Neonatal Mortality

The total neonatal mortality rate declined 66% for white infants and 76% for black infants from 1960 to 1980-82. In the first time period, black infants had higher mortality in every cause-specific category except congenital anomalies. In 1980-82, black infants, despite a larger percent reduction, continued to have higher mortality except in congenital anomalies, external, and systemic causes (Table 1).

In all categories except black infant congenital anomalies, there was at least a 50% reduction in the cause-specific rate. Neonatal mortality in black infants due to infection, asphyxia, and signs/SIDS decreased by more than 80%. White infants experienced similar decreases in asphyxia and perinatal conditions.

The gap in neonatal mortality decreased among the time periods, but black infants are still 1.2 times more likely to experience a neo-

natal death. The greatest difference among the cause-specific categories is in perinatal conditions. Black infants are 3 times more likely to experience death from this cause. Black infants are more likely to die from asphyxia, infection, RDS, and signs/SIDS. White infants are more likely to die from congenital anomalies and systemic disorders.

### Postneonatal Mortality

The total postneonatal mortality rate declined 50% for white infants and 71% for black infants from 1960 to 1980-82. In the first time period, black infants had higher mortality in every cause-specific category except congenital anomalies. In 1980-82, black infants, despite a larger percent reduction, continued to have higher mortality except in congenital anomalies (Table 2).

In less well defined categories, SIDS and signs, the postneonatal period experienced increased mortality. The SIDS diagnosis increased substantially in white infants (300%) over the time period, while black infants experienced a 33% increase. In 1960, black infants were 7 times more likely to have this diagnosis, compared to 2.5 times by 1980-82. Black infants experienced a 50% increase in the sign/symptom category. This result should be used cautiously due to the ICD classification differences within the time period.

Black infants experienced a 91% reduction in mortality due to infections, compared to white infants who experienced a 82% decrease in this category. All other categories had a least a 25% reduction.

The gap in postneonatal mortality decreased among the time periods, but black infants are still 2.2 times more likely to experience a postneonatal death. The greatest differential in the rates is in SIDS. However, black infants are 3 times more likely to experience death from an external cause. Black infants are 2 times more likely to die from infection, SIDS, and systemic disorders.

## Discussion

Cause-specific mortality rates for both black and white infants declined from 1960 to 1980-82 in both the neonatal and postneonatal pe-



riods. The percent declines were greater for black infants in the neonatal period. While mortality differentials between white and black infants narrowed, gaps remained, particularly in the infectious and SIDS categories in the postneonatal period.

The gap in neonatal mortality for normal birthweight infants has narrowed considerably in virtually all cause-specific categories. In the latest time period, the largest differential is in the perinatal category. The next step, which is beyond the scope of this article, would be to examine cause-specific mortality for subgroups, such as urban and rural residents, and to examine the effectiveness of the regionalization system.<sup>1,2</sup>

Declines in postneonatal mortality have been the most dramatic, yet the largest differentials in rates remain. In 1960, there was an extremely large gap between black and white infants, and mortality was almost four times greater in black infants. In 1980-82, mortality is still over two times greater for black infants.

Infection death rates declined, and the gap has narrowed since 1960, but in 1980-82, blacks still experienced higher mortality. Most infection deaths should have been preventable; this may indicate that infants are not being seen in the health care system soon enough. For a child to be seen as expeditiously as possible, both the parents and the health care system must respond promptly and work together in the acute crisis.

### **The SIDS category is the major contributor to the gap in postneonatal mortality and is the leading cause of death for both races.**

The SIDS category is the major contributor to the gap in postneonatal mortality and is the leading cause of death for both races. The higher rate in blacks has been ob-

**TABLE 2 — Cause-specific Postneonatal Mortality Rates\*, By Race, Georgia Resident Births, Infants >2500 grams**

	1960	1974-76	1980-82	% Change
<b>Infection</b>				
White	2.2	0.7	0.4	-82%
Black	11.8	2.9	1.1	-91%
<b>Congenital Anomalies</b>				
White	1.1	0.7	0.4	-64%
Black	1.0	0.6	0.4	-60%
<b>External</b>				
White	0.6	0.3	0.2	-67%
Black	0.9	0.4	0.6	-33%
<b>SIDS</b>				
White	0.2	0.7	0.8	+300%
Black	1.5	1.5	2.0	+33%
<b>Systemic†</b>				
White	0.4	0.4	0.3	-25%
Black	2.1	0.9	0.7	-67%
<b>Signs</b>				
White	<0.1	<0.1	0.1	-
Black	0.2	0.2	0.3	+50%
<b>Total</b>				
White	4.6	3.0	2.3	-50%
Black	17.6	6.7	5.1	-71%

\*Rates per 1,000 live births

†Includes perinatal conditions and RDS/IMM

served repeatedly.<sup>3</sup> An increase in SIDS from 1960 to 1974-76 would be expected, as the syndrome was only defined in 1969.<sup>3</sup> This is the pattern for whites, with rates leveling off 1974-76 to 1980-82. In contrast, for black infants, rates are similar 1960 to 1974-76 but increase by 30% from 1974-76 to 1980-82. This latter increase is of concern. SIDS, while a diagnosis of exclusion, is a specific diagnosis with specific criteria to be fulfilled, including a properly performed autopsy.<sup>3</sup> Not all deaths coded as SIDS are autopsied, and the autopsy rate as coded on the death certificate varies by race. In 1980-82, a total of 54% of both black and white infants who died in the postneonatal period were autopsied. However, of those infants coded as SIDS deaths, 67% of white infants were autopsied compared to 53% of black infants. Many deaths currently classified as SIDS may not in fact be true SIDS deaths.<sup>4</sup>

The enigmatic signs category is unchanged in whites for all three time periods and contains very few deaths. In black infants, however, the rate had fluctuated and has been higher than for white infants. The codes in this category differ somewhat for blacks; there are larger

numbers of cardiac arrest, respiratory arrest, and codes such as acidosis, malnutrition, and dehydration. This category is very likely a "wastebasket" category. A more precise code might have revealed a preventable cause of death.

Deaths from congenital anomalies provide an interesting contrast. This is a major cause of death for both black and white infants. It is the only category in 1960 in which mortality was lower for black than for white infants. The rate of occurrence of some major anomalies is reported to be lower in blacks than whites.<sup>5</sup> From 1960 to 1980-82, mortality for this cause has declined very little for black infants. White infants have experienced a larger percent decline resulting in nearly equivalent rates by 1980-82. Deaths from anomalies are not as preventable or as responsive to the provision of medical care as infection deaths.

The time span studied poses difficulties in comparing ICD classifications. For both the neonatal and postneonatal periods, the categories of infection, external causes, and congenital anomalies are probably the most comparable for all three time periods, although the diagnosis of congenital anomalies



may have improved over time. The perinatal conditions and RDS/immaturity present a problem, as these are very limited in the 7th edition. There is no specific code for RDS in the 7th edition but the "pneumonia of the newborn" code was used. The category of SIDS presents a similar problem. It is not listed in the 7th edition, and the concept was embryonic in 1960. In 1960, the number of deaths in the "suffocation in cradle" code which normally would have been in the external category,<sup>6</sup> appeared to contain SIDS deaths, especially as there are very few deaths with this code in the latter two time periods. Therefore, the 1960 SIDS category includes the "suffocation in cradle" and ill-defined codes. In 1974-76, the majority of deaths in this category are ICD 795.0 (8th edition, sudden death in infant); in 1980-82 the majority are 798.0 (9th edition, Sudden Infant Death Syndrome).

Recently, most interventions have focused on improving perinatal care

resulting in improved neonatal mortality. However, in Georgia the remaining gaps between black and white normal birthweight infants are greater in the postneonatal period. Black normal birthweight infants experience 2.8 per 1000 more deaths than white normal birthweight infants. Three categories, infection, external causes, and SIDS, account for 2.3 per 1000 of these deaths — over 80% of the excess for this weight group. If cause-specific mortality in these three categories for black normal birthweight infants were reduced to the same rate as white normal birthweight infants, postneonatal mortality for black normal birthweight infants would be reduced to 2.8 per 1000 instead of 5.3. This reduction in postneonatal mortality would result in a 12% reduction in the total infant mortality rate for all black infants.

**A** careful review of individual infant deaths, similar to mater-

nal mortality review, should be done not only for a precise definition of cause of death but also for a close examination of the performance of the health care delivery system. While the technology and treatment may exist to reduce mortality, this care must be accessible. The issue is to not only identify the correct interventions to carry out but also to assure that the interventions are done correctly.

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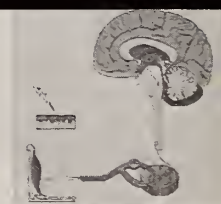
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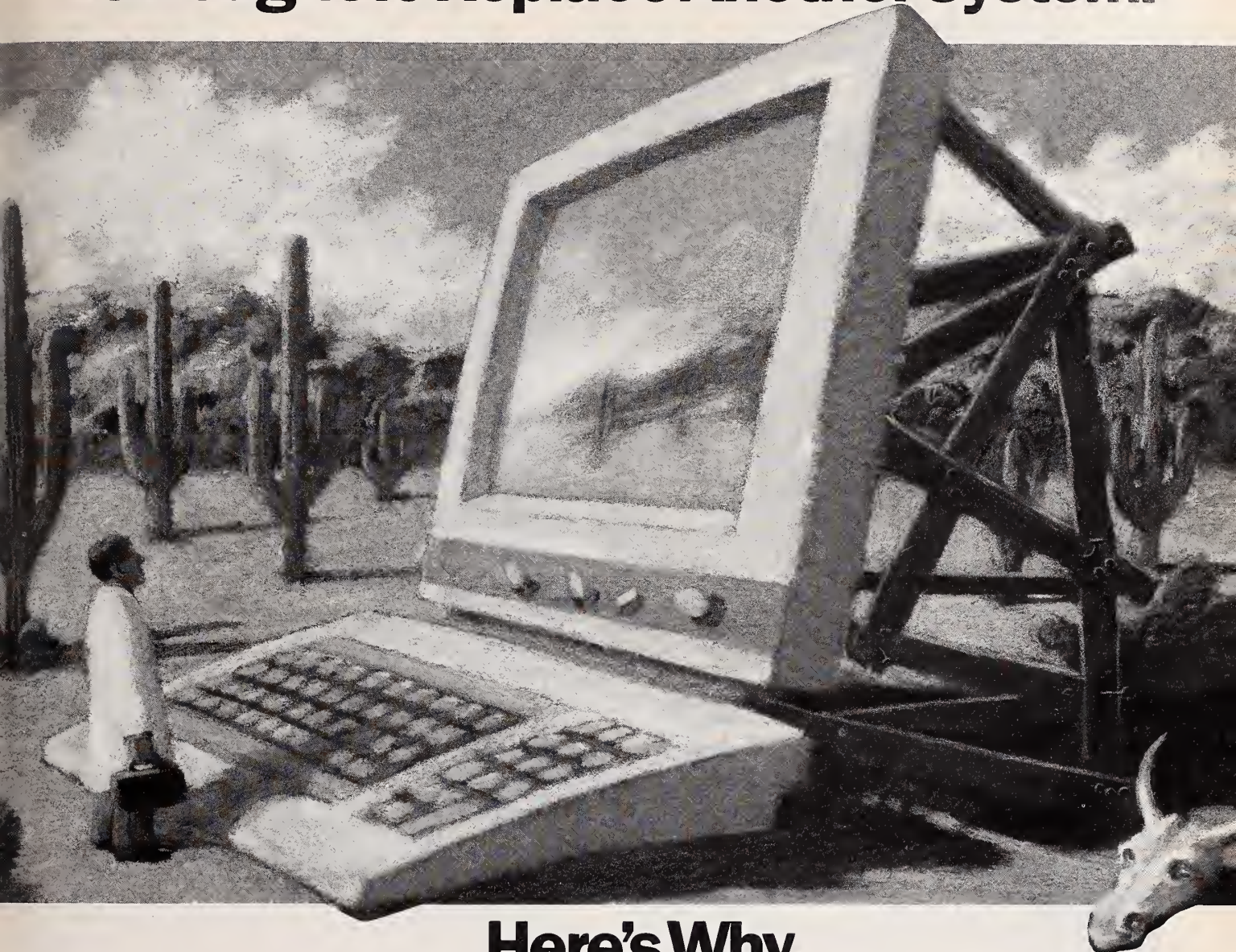
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# YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

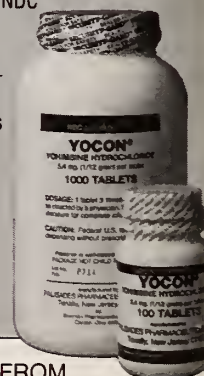
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

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# Medical Experience and Preparedness for Handling Radiation Injuries

Roger E. Linnemann, M.D.

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**This article discusses medical preparedness for nuclear sites in Georgia and shares some of the author's experience in the evaluation, treatment, and counseling of real or suspect radiation overexposures.**

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**Our experience to date shows that medical facilities and physicians in the locale of commercial nuclear power plants can expect to receive contaminated/injured patients about once every 3 to 4 years.**

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## Introduction

**S**IGNIFICANT, ACUTE overexposure to ionizing radiation is an infrequent medical phenomenon. To date, there have been 69 deaths worldwide and nine deaths in the United States.<sup>1</sup> Additionally, 54 workers in the United States since the 1940's have survived total body exposures resulting in severe bone

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Send reprint requests to him c/o Cindy Theiler, Georgia Power Co., P.O. Box 4545, Atlanta, GA 30302.

marrow depression and hospitalization. Most of these have occurred in research and weapons production facilities. No injuries or deaths have occurred from overexposure to radiation in the commercial nuclear power industry since its inception in 1957.

Even though radiation injuries are infrequent, they can be very complex and require medical and radio-

logic resources not always found even in major medical centers. The infrequency also means that few hospitals or medical personnel have had experience in managing these patients. The complexity of these injuries however, is illustrated by the accidents at Chernobyl<sup>2</sup> and Brazil<sup>3</sup> where the medical staffs were faced with multiple patients with complex radiation injuries combined with non-radiation trauma. The management of these patients requires a coordinated team of medical and radiologic specialists supported by a radioassay laboratory and advanced clinical facilities, such as reverse isolation and bone marrow transplantation.

Although a major accident at a nuclear power plant could result in radiation injury to a few plant employees, it is highly unlikely that people in the communities around a plant would be so injured. However, as demonstrated at Three Mile Island, community physicians could be faced with anxious patients seeking information about radiation. This article discusses medical preparedness for nuclear sites in Georgia and shares some of the author's experience in the evaluation, treatment, and counseling of real or suspect radiation overexposures.

### **Regulatory Requirements**

According to the Joint Commission on Accreditation of Healthcare Organizations,<sup>4</sup> every hospital must develop a plan to handle radiation injuries. Furthermore, hospitals with a Nuclear Medicine Department also must have such a plan to maintain a Nuclear Regulatory Commission (NRC) license.<sup>5</sup>

Commercial nuclear power plants, such as the Hatch Nuclear Plant (Baxley, GA) and Vogtle Nuclear Plant (Waynesboro, GA), come under special regulatory requirements for medical preparedness. To operate these plants, the Georgia Power Co. must assure the NRC<sup>6</sup> and the Federal Emergency Management Agency (FEMA)<sup>7</sup> that they have adequate local medical capability to manage radiation injuries. This assurance starts with a letter of agreement from the local hospital stating its willingness to

accept radiation injuries. In return, Georgia Power, through the national nuclear emergency medical assistance program of Radiation Management Consultants, assists the local hospital in the establishment and maintenance of an in-house program for radiation injuries with emphasis on emergency care of the contaminated and injured person. In each of these local hospitals,\* an area has been selected where adequate emergency care can be given while controlling contamination. Special procedures in the setup and use of this area, contamination detection and control, and patient evaluation and decontamination have been written. These procedures are reviewed and if necessary, revised annually. Special equipment and supplies for handling contaminated patients also are provided to the hospital.

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## **The chronologic order of the events of exposure should be carefully documented. . . . All discussions with the patient regarding the accident and radiation effects should be carefully documented.**

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Each year, a coordinated drill/exercise designed to test the plant's capability to provide adequate rescue and first aid of radiation injuries, the local ambulance organization's capability to transport such injuries, and the hospital's capability to provide emergency care and initial radiologic evaluation is conducted. Each drill/exercise is videotaped. Following the drill, a critique is held at the hospital. The participants view the tape and provide immediate discussion and rec-

ommendations. The tape is then edited and is sent along with a written report to each participating medical facility as well as to Georgia Power. Between drills, the tape is used to conduct in-service training for new staff members.

In spite of the fact that the NRC or FEMA does not require nuclear facilities to have equally assured arrangements for definitive evaluation and treatment of complex radiation injuries, Georgia Power felt that a coordinated medical program was needed to ensure that should any of its employees be injured by radiation, he or she would receive the best care possible in a timely manner at centers experienced and equipped to handle such injuries. To provide for this rare but complex and costly care, Georgia Power and 26 other nuclear utilities participate in a nationwide nuclear medical response program called EMAP (Emergency Medical Assistance Program) maintained by Radiation Management Consultants, Philadelphia, PA. Radiation Management Consultants developed the regional approach to the management of radiation injuries in 1970.<sup>8</sup>

In this approach, local medical emergency capability is closely coordinated with medical centers equipped to handle the definitive evaluation and treatment. These centers are Humana Hospital Burn Center, Augusta; Hospital of the University of Pennsylvania, Philadelphia; and Northwestern Memorial Hospital, Chicago. Special expertise in radiation medicine, radiobiology, health physics, and radiochemistry is maintained by Radiation Management Consultants and is available to augment the capability of these centers to provide dose assessment, contamination control, and radiologic consultation for the clinical services treating the various bone marrow, skin, GI tract, and pulmonary complications of internal and external exposure to radionuclides. A specialized accident radioassay laboratory, including mobile whole body counter, is maintained by Radiation Management Consultants for this purpose. Training, drills, and committee meetings are held at each center annually to maintain their

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\*Appling General Hospital, Baxley; Dr. John Meadows Memorial Hospital, Vidalia; Burke County Hospital, Waynesboro; Humana Hospital, Augusta.



interest and proficiency. A nationwide air evacuation system, MedEscort International, Inc. is part of EMAP and would be used to transport a team of specialists (Radiation Emergency Medical [REM-] Team) to the local hospital within hours of the accident to assist in radiologic evaluation, triage, and evacuation, if necessary. Radiation Management Consultants maintains this REM-Team for consultation and dispatch on a 24-hour basis. This response system (EMAP) is very much like the medical response the Soviets used successfully to handle the 203 victims that were hospitalized as a result of the accident at Chernobyl.<sup>2</sup>

### **Radiation Injuries**

Because radiation injuries are seldom if ever life-threatening, the treatment of accompanying serious trauma or illness takes precedence over evaluation and treatment of radiation injuries. Once the dose, based on initial symptoms and/or physical measurements, is known, the clinical course is predictable and unfolds over time (usually days and weeks).

Radiation injuries can be classified according to the relationship of the radiation source to the patient and by the clinical picture evoked by the exposure.

The usual result of irradiation by a large radiation source outside and not in contact with the body is whole body exposure. This kind of exposure may occur in criticality accidents with large X-ray or gamma sources. These patients are not in themselves radioactive. They do not constitute a hazard to the attendants. Clinically, whole body exposure is characterized by the appearance of signs resulting from a depression of the hematopoietic system: general weakness, decreased resistance to infections, and increased bleeding tendency. With low doses, i.e., under about 100 rad, these signs (if any) will be minimal. With very high doses, i.e., over about 1,000 rad, the clinical picture is entirely determined by extensive anatomic and functional damage to the gastrointestinal tract, leading to severe and practically irreversible

disturbances of the fluid and electrolyte equilibrium in the body. Sepsis is also a major complication.

### **Partial Body Exposure**

In partial body exposures, the source is usually very near the body. In this type of exposure, for obvious reasons, the affected parts of the body (usually the extremities) receive a much higher dose than the rest of the body. An example of this situation is the industrial radiographer who attempts to manually return a radiation source to its shielded storage. In other situations, severe finger exposures can occur during the adjustment of an X-ray diffraction apparatus.

The clinical picture of local radiation injury consists of erythema, edema, vesiculation and, with high doses, tissue necrosis.

### **External Contamination**

The presence of radioactive materials on the body or clothes is external contamination. In the absence of other external exposure to penetrating radiation, external contamination represents predominantly a risk to the skin, as the dose to superficial layers of the body is much higher than that to deeper lying organs. From a practical point of view, externally contaminated patients may represent a risk to both attendants and the medical facility itself because of possible spread of radioactive materials.

### **Internal Contamination**

Inhalation, ingestion, or absorption of radioactive materials through wounds results in internal contamination. Depending upon the biochemical behavior of the nuclides concerned, these materials will either be deposited throughout the entire body or be concentrated in specific organs. In the great majority of cases, the total body dose will be too low to cause an acute radiation syndrome, but the dose to the organs in which radionuclides are deposited may be appreciable. Unlike the externally contaminated patient, the patients with an internal contamination is not a hazard to other people or to the hospital.

The amount of radioactivity excreted in feces and urine is usually too small to present a hazard. The diagnosis and treatment of internally deposited radionuclides, however, is a special problem in itself.

### **Special Cases**

Special cases are those in which a combination of exposures, or the existence of concomitant non-radiation injury, require complex measures to ensure both optimal medical care and protection of attending personnel. An example of a special case is the patient who, as a consequence of an explosion involving radioactive materials, has a radioactive foreign body embedded in his abdomen.

### **Diagnosis of Acute Radiation Syndrome**

The diagnosis of acute radiation syndrome is made on the basis of the initial symptoms along with an awareness or confirmation of a major portion of the torso having been exposed to penetrating gamma or X-irradiation. In most cases, initial dose estimates will be unavailable or unreliable. Complete blood counts including platelets should be initiated and repeated every 3 to 4 hours. In suspect or asymptomatic cases, these should be continued until further confirmation of dose received is obtained. The depth of the drop in neutrophil count and the time over which it occurs is indicative of the dose received. Initially, the patient may develop a leucocytosis. This can be wrongfully interpreted as lack of exposure to ionizing radiation. This initial leucocytosis, however, is due to stress and is only temporary. Below 200 rad, the neutrophile drop is not profound. Depending upon the patient's general health, secondary signs and symptoms of infection and bleeding will be mild or absent. Over 500 rad, a marked drop will occur within a few days. An abortive rise between 12-16 days indicates a dose range of 200-500 rad. This rise may be due to toxic reaction from earlier cellular destruction. Lymphocytes will drop



early and fast with high doses. Less than 300 mm<sup>3</sup> in the first 24-48 hours indicates a poor prognosis; above 1200 mm<sup>3</sup>, a good prognosis. With the exception of known low exposures (below 5 rad) arrangements should be made for radiation cytogenetic studies. Chromosome analysis of circulating lymphocytes will show dicentrics, tracentrics, and rings. The number per cell is linearly related to uniform exposures between 15-600 rad. Platelets and red cells are less sensitive and reach their nadir long after that of white cells. Another aid in diagnosis is the sperm count. This count can be affected with doses as low as 15 rad. Below 100 rad, the count may not drop until 40-60 days later when the results of the damage to spermatogonia manifest themselves. At doses above 300 rad, the drop in the sperm count will occur within days. A dose-effect relationship for total body exposures of penetration radiation received in a brief time can be seen in Table 1.

spond to symptomatic treatment. Anxiety will be an ongoing symptom as the course of radiation injury unfolds. Well-meaning but misinformed friends and relatives may add to the patient's anxiety with their own fears about radiation. The patient will have fears about sterility, infertility, genetic disorders, and cancer. The chronologic order of the events of exposure should be carefully documented. Any significant overexposure is likely to become a medical-legal problem. All discussions with the patient regarding the accident and radiation effects should be carefully documented.

Following the initial treatment, the attending physician should seek the services of experts in accident analysis and dosimetry. The clinical course and estimate of dose will dictate the subsequent course of action: follow up on an outpatient basis, hospitalization and observation locally, or transfer to a specialized care center.

of the injury. Except for massive overexposures, patients exhibit few early signs and symptoms. The first sign will be erythema. This may be transient and recur over days and weeks. In dark-skinned people, it may be missed altogether. If erythema occurs early and is accompanied by blanching, a very large exposure has occurred. As the dose increases, the skin reaction progresses to dry desquamation, wet desquamation, ulceration, and chronic radiodermatitis. This course usually develops over weeks and months. Epilation will occur when absorbed doses to the hair follicle exceed 300 rad. It appears about 10-14 days following exposure. Unlike total body exposure, dose-effect relationships are difficult to correlate. With low energy X-ray, erythema can be produced with as little as 400 rad. Fission products will produce erythema with about 800 rad. It takes about 1500 rad absorbed dose to the germinal layer of skin to produce wet desquamation; higher doses (about 2500 rad single exposure) can lead to ulceration. Since lesions can develop as late as 2-3 weeks, early prognostication should be avoided. The underlying pathology of the skin from penetrating radiation (gamma or X-ray) is an obliterative endarteritis. This may result in necrosis and gangrene. Symptoms of total body exposures may be accompanied by skin effects. With a total body dose of penetrating gamma or X-ray of 300 rad or more, erythema may also develop. This should alert the physician to future serious bone marrow depression.

**TABLE 1 — Dose-Effect Relationship\***

5 Rad	No observable effects
15 Rad	Cytogenetic effect
50 Rad	Blood threshold
100 Rad	Symptom threshold
600 Rad	Approx. 100% lethality

\*Total body irradiation; Brief exposure (hrs.); Penetrating gamma radiation or x-rays.

### Treatment

If contamination has been ruled out, the externally exposed patient can be handled as a routine emergency room case. No special precautions are required. The patient will experience feelings of anxiety and fear. In addition to symptomatic treatment for nausea and vomiting, a mild sedative may be required. The patient should receive a complete physical exam even though few initial signs are evident. Whatever facts of the overexposure are available should be explained in clear, understandable terms. Unless a massive dose has been received, patients will re-

### Local Radiation Injuries

External exposure to a part of the body is the most common radiation injury recorded. This can occur through direct contact with a sealed source of radioactive nuclides, e.g., industrial radiography source or implants used in cancer treatment. It can occur when a part of the body is overexposed to an external beam of X-irradiation or through contamination with loose radioactive materials. As a general rule, if you can't see the contaminated "dirt," it is unlikely to cause skin damage. The energy, the dose, dose rate, and volume of tissue involved will determine the extent and seriousness

### Diagnosis and Treatment

The early diagnosis of local radiation injury is made by a history of exposure followed by erythema. Patients exhibit very few, if any, early signs and symptoms. Though thermal and radiation burns may have a similar appearance, radiation erythema is usually not accompanied by pain. Colored photographs should be taken initially and later to follow the progression of lesions. If the exposure involves the face, serial split-lamp examination of the lens of the eye should be done. With



suspected high exposures, periodic X-rays of underlying bone tissues are obtained for development of radionecrosis. Blood studies are done to rule out an accompanying total body exposure. In many cases, radiation-induced skin lesions will present as a chronic dermatitis. Only a history and high degree of suspicion will reveal the underlying cause.

Usually very little in the way of treatment is required on an emergency room basis. The patient will be anxious. Dose information and detailed history of the accident should be obtained as soon as possible. This will alert the physician to further problems. The patient is followed on an outpatient basis at biweekly and later weekly intervals. Further exposure to radiation and trauma should be avoided. Definitive care may involve conservative treatment for infection, tissue regeneration, and pain. Split thickness, full thickness grafts, or even amputation may be required.

**Experience**

Radiation Management Consultants has maintained an EMAP for 25 commercial nuclear power sites located in 14 states for the past 20 years. There are a total of about 40,000 radiation workers at these sites. Of the 308 consultations seen since 1970, about one-half came from the commercial nuclear power industry. To date, no significant (i.e., requiring active medical intervention and/or hospitalization) accidental overexposure to radiation has been seen in a commercial nuclear power plant. The highest level of total body external penetrating radiation exposure seen was 20 rem. The patient required evaluation and radiation counseling but no active medical treatment. Also during this time, 63 cases of contaminated and injured or ill patients were taken from a nuclear power plant to a local hospital. This experience shows that if a hospital was to receive a contaminated/injured or ill patient from a nuclear power plant, the hospital could expect the injury or illness to be quite severe. Patients with less severe injuries are normally decontaminated

at the plant before being dispatched to the hospital. The contamination in all cases was of nuisance levels, varying from a few hundred counts per minute to the highest level of 20mR/hr. The latter was found on the right hand and face of a patient involved in an explosive accident involving loose radioactive materials. This is the highest level of contamination ever taken to a hospital from a nuclear power plant. During the decontamination of this patient, the maximum exposure to the attendants in the emergency room was 14 mrem. This is about equivalent to the exposure of one chest x-ray.

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**The large mass of combustible material (2700 tons of graphite) in the Chernobyl reactor, along with the lack of containment, were the underlying causes for the number and severity of radiation injuries. . . . Without the fire, it is unlikely that so many people would have been exposed to such high levels of radiation.**

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There were five cases of radioactively contaminated puncture wounds. In all but one, the contamination was completely removed by either scrubbing, allowing the puncture wound to bleed, or by removing the contamination with a small elliptical, surgical excision. In one case, the contamination was deeply embedded. In view of the small amount of contamination (800cpm of Cobalt-60), further surgical procedures were not warranted. Our experience demonstrates that hospitals are able to handle very severely injured contaminated patients while control-

ling the contamination to a designated area.

The six medically significant cases of overexposure were all local external exposures and were referred from users of industrial radiography, manufacturers of radiation sources, and research institutes. The highest exposure in this category was 100,000 rem delivered over a period of 8 years to the hand of a worker who was decontaminating industrial radiography sources. The right first finger has since been amputated. Pathologic examination revealed two areas of carcinoma in situ.

**Future Planning**

Our experience to date shows that medical facilities and physicians in the locale of commercial nuclear power plants can expect to receive contaminated/injured patients about once every 3 to 4 years from a local commercial nuclear power plant. Large accidents likely to produce significant radiation casualties are even more infrequent.

The only major commercial reactor accident in this country, Three Mile Island in 1979, resulted in two workers receiving doses of 3-4 rem total body; several others received Beta skin exposures (about 300 rem), neither of which resulted in acute injury.

The Chernobyl accident resulted in medically significant overexposures to 203 employees and rescue workers at the plant. Overexposures not presenting with clinical signs and symptoms numbered in the hundreds.<sup>2</sup> Of the 203 patients that were hospitalized, 29 died. The deaths were due to a combination of thermal burns, radiation skin damage, and hematopoietic depression. In 20 of these patients, the skin damage from both thermal and radiation alone could have resulted in death. Considering radiation accidents that have occurred in the past in this country, and the marked difference in design of the Chernobyl reactor compared to those in the U.S., it is reasonable to assume that many fewer casualties would result from an accident in a U.S. commercial nuclear power plant.

The large mass of combustible material (2700 tons of graphite) in the Chernobyl reactor, along with the lack of containment, were the underlying causes for the number and severity of radiation casualties. Firemen and rescue crews were working in very large radiation fields (100-200 R/hr) and under very hot thermal conditions. Without the fire, it is unlikely that so many people would have been exposed to such high levels of radiation.

#### Summary

Medically significant overexposures have not occurred in 30 years of operating commercial nuclear power plants in this country. However, the medical communities around reactors in Georgia as well as the rest of the country, maintain a vigilance and preparations to handle these cases through semi-annual exercises using simulated patients. The programs at the Hatch and Vogtle plants provide not only

**Medically significant overexposures have not occurred in 30 years of operating commercial nuclear power plants in this country. However, the medical communities around reactors in Georgia . . . maintain a vigilance and preparations to handle these cases through semi-annual exercises. . . .**

for local care but also for specialty medical teams to arrive and assist in the triage and evacuation of casualties to definitive care centers for complete evaluation and treatment. This is not unlike the plan the Soviets used so successfully at Chernobyl.

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**Contraindication:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

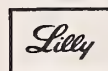
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

**Abnormalities in laboratory results of uncertain etiology**

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
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## Application of Criminal Antitrust Sanctions to Health Care Professionals

Robert N. Berg

**U**NLESS YOU HAVE BEEN practicing medicine in a cave for the last 13 years, you are well aware of the fact that the U.S. antitrust laws are applicable to health care professionals. This was the lesson of the U.S. Supreme Court's 1975 decision in the *Goldfarb*<sup>1</sup> case — that members of the "learned professions" (e.g., physicians, attorneys, architects, engineers, etc.) are subject to the antitrust laws, just the same as persons and entities involved in other trades and businesses.

For the most part, the challenges that have arisen over the past 13 years to the activities of health care professionals have been *civil* actions. That is, private parties, or the Federal Trade Commission, have sought damage suits or claims for injunctive relief, in order to remedy alleged antitrust violations. Conversely, there has been little activity over the last 13 years in the enforcement of the *criminal* antitrust statutes against health care professionals. It appears that this is about to change, however, and this article is designed to provide physicians with an overview of the "criminal" side of the U.S. antitrust laws.

### Criminal Antitrust Penalties

The U.S. antitrust laws provide for both civil and criminal enforcement. The more widely-known civil provisions are

**‘Initially, rather than attempt to enforce criminal sanctions against violative conduct in the health care field, the Department of Justice has instead elected to educate health care professionals on the application of the antitrust laws to those activities. . . . It now appears that the Department’s “education effort” may be over and that it is prepared to commence criminal proceedings against health care professionals engaging in “hard core” antitrust violations.’**

designed to bring unlawful activities to a halt and to restore competitive conditions. This is accomplished through the awarding of treble damages (three times actual damages) to the injured party; injunctive relief is also available in certain situations.<sup>2</sup> The antitrust laws also authorize the imposition of fines and prison sentences on those responsible for the unlawful conduct. Specifically, a violation of the antitrust laws constitutes a *felony*, the punishment for which may include fines of up to \$250,000 for individuals and \$1,000,000 for corporations, and prison sentences of up to 3 years.<sup>3</sup> The Department of Justice is exclusively responsible for the enforcement of these criminal sanctions.

Traditionally, the criminal antitrust penalties have been reserved for certain types of "hard core" violations — price fixing, bid-rigging, certain types of horizontal boycott activities, etc. In certain cases, however, the Department of Justice has chosen to exercise its prosecutorial discretion and seek civil remedies, as opposed to criminal penalties. This may be done for a number of reasons, including where: (1) there is confusion as to the applicability of the law to particular conduct; (2) there are truly novel issues of law or fact presented; (3) there is confusion caused by past prosecutorial

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decisions; or (4) there is clear evidence that the subjects of the investigation were not aware of, or did not appreciate, the consequences of their actions.<sup>4</sup>

Since 1975, the health care profession has received the benefit of the exercise of this prosecutorial discretion by the Department of Justice. Rather than attempt to enforce criminal sanctions against violative conduct in the health care field, the Department of Justice has instead elected to educate health care professionals on the application of the antitrust laws to those activities. Thus, the Department filed civil suits seeking to enjoin what it perceived as unlawful conduct, in lieu of seeking criminal sanctions. Officials in the Department also gave numerous speeches explaining how the Department's approach to antitrust enforcement was intended to operate.

**Application of Criminal Sanctions to Conduct by Health Care Professionals**

It now appears that the Department's "educational effort" may be over and that the Department is now prepared to commence criminal proceedings against health care professionals engaging in "hard core" antitrust violations. This was the thrust of remarks made by Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S.

Department of Justice, at the interim meeting of the AMA House of Delegates held in Dallas, Texas on December 6, 1988.

Specifically, Mr. Rule discussed certain "naked" agreements among competitors, agreements which are viewed by the Department as unlawful and, as a result, *will be prosecuted criminally*. As described by Mr. Rule:

*"Clear violations of the antitrust laws occur when otherwise competing professionals agree to do something, or to refrain from doing something, that blocks the free operation of the competitive process without any plausible promise of economic benefits for consumers. Such activity neither involves the creation of any real efficiencies — it does not provide something that consumers want at less cost than could be done through independent action — nor offer some new 'product' that would otherwise be unavailable. Instead, it is activity that just eliminates competition, raises prices, reduces the quantity of services provided, and thus reaps increased profits for physicians. When this is the case, it makes no difference whether the enriched doctors line their pockets with these profits or use them to increase the quality of care. 'Naked' agreements of this*

*kind — to fix prices, to allocate territories, or to boycott competing health-care providers — are unlawful regardless of their purpose and effect."*

Mr. Rule then went on explain to his audience that the Department currently was looking into numerous allegations of possible criminal violations by physicians and physician groups. He cited examples involving physicians organizing to block new delivery systems by agreeing to withhold their services; groups of independent doctors, while in the process of negotiating with PPOs, meeting secretly to agree to a minimum price or to other terms that they will insist upon when they discuss their participation in the PPO; and, physicians agreeing to allocate patients among themselves on the basis of patient residences or some other criteria. Moreover, Mr. Rule warned his audience that the Department is "on the lookout for other possible violations that merit criminal investigation," and that the Department is "prepared to indict and fully prosecute the professionals involved if the evidence warrants it."

Finally, Mr. Rule provided "a set of basic, simple, and easy-to-remember rules," to assist physicians in avoiding criminal violations. These rules included:

*"First, do not agree with competing independent doctors*

on any term of price, quantity, or quality — including fee schedules and relative value scales;

Second, do not agree with competing independent doctors on the patients you are willing to serve, the locations from which you are permitted to draw patients, or where you will locate your offices; and

Third, do not agree with competing independent doctors to refuse to offer your services to alternative delivery systems.”

Mr. Rule acknowledged that even these general rules could be subject to exceptions, most notably where the “agreement” involved is in the context of participation in a legitimate alternative delivery system.

#### Conclusion

In sum, it appears that the antitrust regulators have now shifted gears and are prepared to deal with the health care

**“The Assistant Attorney General, in his talk to the AMA House of Delegates last December, provided a set of basic, simple, and easy-to-remember rules to assist physicians in avoiding criminal violations.”**

profession as they have dealt with other trades or businesses in the past — by seeking to impose criminal sanctions on professionals who engage in unlawful price fixing, concerted refusals to deal, and other “hard core” antitrust offenses. Thus, we can expect to see a significant increase in the number of criminal prosecutions, alleging violations of the U.S. antitrust laws by physicians and other health care professionals.

#### Notes

1. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).
2. See Sections 4 and 16 of the Clayton Act, 15 U.S.C. §§15, 26.
3. See Antitrust Procedures and Penalty Act of 1974, amending 15 U.S.C. §§1-3; Criminal Fine Enforcement Act of 1985, 18 U.S.C. §3623.
4. See U.S. Department of Justice, Antitrust Division Manual III-11 (1982); Remarks by Donald I. Baker, Assistant Attorney General, Antitrust Division, U.S. Antitrust Enforcement — Criminal v. Civil Prosecution (Arlington, Virginia, February 28, 1977), *reprinted in* [Current Comment — 1969-1983 Transfer Binder] CCH Trade Reg. Rep. Para. 50,335.



## *Advances in the Treatment of Non-Hodgkin's Lymphoma*

*James M. Jones, II, M.D.*

**T**HE NON-HODGKIN's lymphomas (NHL) are a heterogeneous group of lymphoid malignancies which possess a wide variety of pathologic, cytologic, immunologic, and molecular biologic differences. Despite these differences, most NHL fall into two broad therapeutic categories: the nodular indolent types and the diffuse aggressive varieties.<sup>1</sup> Patients with indolent lymphomas (characterized by nodular or follicular architecture and small cell size) commonly present with widespread disease including bone marrow and liver involvement. Less than 10% will present with extranodal disease, and fewer than 20% have constitutional symptoms. In contrast, aggressive lymphomas (characterized by diffuse architecture and large cell size) have a very different natural history. About 45% present with constitutional symptoms but, paradoxically, documented generalized disease is somewhat less common than in patients with indolent lymphomas.

For many years, the Rappaport classification, based on pattern of growth (nodular or diffuse) and the predominant cell type (lymphocyte or histiocyte) was used for NHL. As more extensive information on cytologic origin and immunology became available in recent years, the National Cancer Institute (NCI) developed the International

**‘Non-Hodgkin's lymphoma, virtually fatal 25 years ago, can now be treated with four or five different intensive combination chemotherapy regimes capable of producing 70-80% complete remissions.’**

Working Formulation. This classification scheme divides the NHL into low-grade, intermediate-grade, and high-grade varieties. The distinction between nodular (follicular) and diffuse patterns has been retained, but the malignant cell types are referred to as small cell and large cell rather than lymphocytic and histiocytic types. A comparison of the new classification and its Rappaport equivalents can be found in Table 1.<sup>2</sup>

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This paper was sponsored by the Georgia Division of the American Cancer Society. Those wishing to contribute papers to the Section should send them to Dr. Tom Phillips, CANCER Section Editor, 25 Prescott St., Atlanta, GA 30365.

### **Nodular Indolent Lymphomas**

Despite the fact that more than 80% of the nodular indolent lymphomas present with either disseminated nodal (stage III) or visceral (Stage IV) disease, these lymphomas are highly responsive to a wide variety of chemotherapy regimens. Complete remission rates in the 60 to 75% range are common, with the median duration of such remissions ranging from 17 to 24 months. By 4 years after treatment, 80% of patients have experienced recurrence of disease. While the 5-year survival rate is greater than 70%, the 10-year survival rate is only 30%. Thus, the failure of existing chemotherapy or radiotherapy approaches to cure indolent lymphomas has led to a variety of palliative approaches to management. These include single agent chemotherapy, combination chemotherapy with two or three drugs, biologic response modifiers such as interferon, or a "watch and wait policy" (only administering therapy when symptoms necessitate intervention). The clinical course of most patients with the low-grade indolent lymphomas becomes one of repeated remissions followed by recurrence of disease. Eventually, the patient succumbs to drug-resistant lymphoma or to other medical illness (cardiovascular disease, cerebrovascular disease, diabetes, etc.).

TABLE 1 — Pathologic Classifications of NHL<sup>16</sup>

	<i>Working Formulation for Clinical Usage</i>	<i>Rappaport equivalent</i>
Low grade:	Malignant/lymphoma: Small lymphocytic	Diffuse well-differentiated lymphoma/ chronic lymphatic leukemia (DWDL/CLL)
	Follicular, small cleaved cell	Nodular, poorly-differentiated lymphoma (NPDL)
	Follicular, mixed small and large cell	Nodular, mixed lymphoma (NML)
Intermediate grade:	Follicular, predominantly large cell	Nodular, histiocytic lymphoma (NHL)
	Diffuse, small cleaved cell	Diffuse, poorly-differentiated lymphoma (DPDL)
	Diffuse, mixed small and large cell	Diffuse, mixed lymphoma (DML)
	Diffuse, large cell	Diffuse histiocytic lymphoma (DHL)
High grade:	Large cell, immunoblastic	Diffuse, histiocytic lymphoma (DHL)
	Large cell, lymphoblastic	Lymphoblastic — convoluted/non-convoluted
	Small noncleaved cell	Diffuse, undifferentiated lymphoma (DUL) Burkitt's and non-Burkitt's

### Diffuse Aggressive Lymphomas

Most of the lymphomas considered historically as diffuse aggressive lymphomas now fall into the Working Formulation's intermediate and high-grade categories.

These tumors have a high growth fraction with a rapid doubling time. Prior to the 1970s, single agent chemotherapy produced complete remissions in only 5% of patients with advanced disease, and survival was consistently less than 1 year. Until recently, salvage chemotherapy after initial relapse was rarely successful. Most patients died within the first two years after diagnosis. The past decade has witnessed a major change in the outcome of these diffuse aggressive lymphomas, and the probability of patients remaining alive and free of disease after 10 years is now better for patients with diffuse lymphomas than for those with so-called indolent lymphomas.<sup>3</sup>

### Advances in Chemotherapeutic Regimens

The past 10 to 15 years has seen an evolution in the

chemotherapeutic regimens used to treat the diffuse aggressive lymphomas in general and diffuse large cell lymphoma in particular. Single agent chemotherapy resulted in uncommon complete remissions, durations of remission of 4 to 6 months at best, and only rare long-term survivors. In the early 1970s, first-generation combination chemotherapy (CVP) showed the potential curability of large cell lymphoma, with a 5-10% survival rate. A fourth drug, procarbazine, added to the standard three-drug CVP regimen, enhanced survival to approximately 35% (alive and continuously free of disease with no maintenance therapy after 5 years).<sup>4</sup> This was the first study to demonstrate that patients who initially had complete remissions could remain disease-free without further therapy and that some patients with advanced disease (Stage III and IV) were curable. It was noted that most relapses from a complete remission occur within 2 years when the survival curves begin to plateau. Once the documentation of Doxorubicin's (Adriamycin) activity in this disease was established, several Doxorubicin-based multiagent regimens were introduced. CHOP

produced complete response (CR) rates of 60% or more with, 39% of patients experiencing recurrence.<sup>5</sup> Overall, the long-term survival rate with CHOP is 31%. All of the early, first-generation regimens were administered every 21-28 days, and the large cell lymphoma seemed to recur between treatment cycles. In an attempt to limit these intercycle recurrences, regimens using myelosuppressive drugs alternating with non-myelosuppressive drugs such as Bleomycin were devised. One such regimen, BACOP, produced complete remissions in 48% of patients, but after 5 years, only 40% of all patients treated were surviving free of disease off all therapy.<sup>6</sup> Thus, the addition of these agents failed to substantially improve the overall survival which remained at 35-40%.

In the late 1970s, several studies reestablished the activity of antimetabolites, such as methotrexate and cytosine arabinoside, against diffuse lymphomas (Table 2). A second-generation of regimens utilizing five or six drugs and more frequent scheduling came into use (COMLA,<sup>7</sup> COP-BLAM,<sup>8</sup> M-BACOD,<sup>9</sup> ProMACE-MOPP<sup>10</sup>).



**TABLE 2 — Glossary of Combination of  
Chemotherapy Regimens for NHL<sup>16</sup>**

<b>BACOP</b>	= bleomycin, Adriamycin (doxorubicin), cyclophosphamide, (Oncovin) vincristine, prednisone
<b>C-MOPP</b>	= cyclophosphamide, (Oncovin) vincristine, procarbazine, prednisone
<b>CHOP</b>	= cyclophosphamide, doxorubicin, (Oncovin) vincristine, prednisone
<b>CHOP/HOAP-Bleo/IM VP-16</b>	= Cyclophosphamide, Adriamycin (doxorubicin), (Oncovin) vincristine, prednisone, Adriamycin (doxorubicin), (Oncovin) vincristine, cytarabine, prednisone, bleomycin, ifosfamide, methotrexate, etoposide (VP-16)
<b>COMLA</b>	= cyclophosphamide, (Oncovin) vincristine, methotrexate with leucovorin rescue, cytosine arabinoside (cytarabine)
<b>COP-BLAM</b>	= cyclophosphamide, (Oncovin) vincristine, prednisone, bleomycin, (Adriamycin) doxorubicin, procarbazine
<b>F-MACHOP</b>	= 5-fluorouracil, methotrexate, Adriamycin (doxorubicin), cyclophosphamide, (Oncovin) vincristine, prednisone, cytarabine
<b>M-BACOD</b>	= methotrexate with leucovorin rescue, bleomycin, Adriamycin (doxorubicin), cyclophosphamide, (Oncovin) vincristine, dexamethasone
<b>MACOP-B</b>	= methotrexate with leucovorin rescue, Adriamycin (doxorubicin), cyclophosphamide, (Oncovin) vincristine, prednisone, bleomycin
<b>MOPP</b>	= mechlorethamine, (Oncovin) vincristine, procarbazine, prednisone
<b>ProMACE</b>	= prednisone, methotrexate with leucovorin rescue, Adriamycin (doxorubicin), cyclophosphamide, etoposide (VP-16)
<b>ProMACE/CytaBOM</b>	= cyclophosphamide, Adriamycin (doxorubicin), etoposide (VP-16), cytarabine, bleomycin, (Oncovin) vincristine, methotrexate
<b>ProMACE-MOPP</b>	= cyclophosphamide, doxorubicin, VP-16, methotrexate with leucovorin rescue, prednisone, nitrogen mustard, (Oncovin) vincristine, procarbazine, prednisone

of Stage IV patients, 50% of those with bone marrow involvement, and 64% of patients with GI tract masses. Thus, the most dramatic change in CR occurred in the groups that had been historically the most difficult to treat effectively. These newer, second-generation regimens coupled a higher CR rate with a relatively low, (17 to 26%) relapse rate, producing overall 3-year, disease-free survival rates of 60 to 70%, in contrast to the 35 to 40% for regimens used earlier. These improvements in therapy were not accomplished easily, however, as 5 to 10% of patients treated with many of these regimens died from treatment-related causes. In addition, the regimens are complicated, not easily used in non-research hospitals or office practice settings, and often require hospitalization for monitoring.

**I**n an effort to improve the dose intensity of NHL regimens and complete induction therapy more rapidly in hopes of decreasing toxic side effects, a series of third-generation protocols have been devised. These are characterized by alternative modes of drug administration, greater use of cycle-active and marrow-sparing agents, use of noncross-resistant drugs, and more frequent dosing schedules. Examples of such regimens are COP-BLAM III, ProMACE-CytaBOM, and MACOP-B. These produce CR rates between 80 and 85%, with a plateau phase at approximately 65 to 70%.<sup>12</sup> Upwards of 70-88% of CRs have been maintained for 2 years. These results seem to occur even in patients with poor prognostic factors, such as bulky abdominal disease. To obtain high remission rates, one must adhere closely to the dose and schedule recommended for that

These regimens produced CRs greater than 70% and a survival plateau of 55-60%. In diffuse aggressive lymphomas, certain prognostic factors have been shown to adversely affect treatment outcome. These include presence of B symptoms (fever, night sweats, or weight loss

greater than 10% of body weight), bulky disease (masses greater than 10 cm.) especially those involving the GI tract, and bone marrow involvement or other Stage IV disease.<sup>11</sup>

Pro MACE-MOPP produced a 74% CR rate overall which interestingly included CRs in 66%



particular regimen. The bottom line with all therapies is the number of patients in continuous CR for 2 years. All third-generation regimens compare favorably, with 2-year survival rates of 70-88%, which is considerably better than 35-40% as seen with first-generation therapies.

One important new regimen of this design is MACOP-B, in which induction therapy is completed in a weekly 12-week sequence.<sup>13</sup> Myelosuppressive drugs, adriamycin and cytoxan, are alternated with non-myelosuppressive agents, bleomycin, vincristine, and high-dose methotrexate with leucovorin rescue. Trimethoprim-sulfamethoxazole and ketoconazole are given orally throughout the induction period to prevent or reduce infections caused by *Pneumocystis carinii* and fungi. Prednisone is given daily throughout the 12 weeks of therapy. Mucositis occurs in 40-50% of patients on this regimen and is the dose-limiting toxicity. Measures such as ketoconazole, attention to good oral hygiene, vigorous treatment of herpetic mucositis with both topical and oral acyclovir, avoidance of medications that alter creatinine clearance (which may prolong clearance of methotrexate), and generous fluid administration with alkalinization of the urine have reduced the severity of mucositis.<sup>14</sup> Despite the side effects, the rate of toxicity-related deaths was 3% with MACOP-B treatment. Initial reports showed an 84% CR rate with only a 10% recurrence rate. Actuarial overall survival for the entire group of patients treated was 76% and was estimated to be as high as 90% for those achieving a CR. A more recent update of MACOP-B data indicates a 16% recurrence frequency and a long-term survival of 66% for all patients.<sup>15</sup>

## ‘The failure of existing chemotherapy or radiotherapy approaches to cure indolent lymphomas has led to a variety of palliative approaches to management.’

### Summary

The use of more aggressive multiagent combination chemotherapy for the treatment of advanced diffuse aggressive lymphomas has resulted in a dramatic change in the overall outlook in patients with this disease. Once rarely curable or even controllable, it is now one of the most curable of disseminated malignancies. Sustained, disease-free survival rates have risen from 5% in the 1960s to approximately 65% in the 1980s. The 35% who do not achieve initial CR generally experience a fulminant course, with patients rarely surviving more than 2 years. Subsequent clinical trials will explore a number of new approaches including short-course, dose-intense induction regimens, addition of new agents into combinations (including cisplatin, vindesine, M-AMSA, ifosfamide, and methyl-GAG), and the use of biologicals (monoclonal antibodies, interleukin-2 plus LAK cells, and tumor necrosis factor). Salvage therapy for those who experience recurrence of disease can produce responses in 45 to 65% of patients, but remission duration is short, and median survival time is usually less than 1 year. Recent interest in high-dose chemotherapy with or without total body irradiation, followed by autologous bone marrow

transplantation for relapsed patients, has produced some encouraging results.

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**Contraindications:** VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions:** **General:** **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Oosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium ( $> 5.7$  mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients:

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

#### Drug Interactions:

**Hypotension: Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of  $^{14}$ C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**Hypertension:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**Heart Failure:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

#### Clinical Laboratory Test Findings:

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration:** **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Oosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance  $> 30$  mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance  $\leq 30$  mL/min (serum creatinine  $\geq 3$  mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium  $< 130$  mEq/L) or with serum creatinine  $> 1.6$  mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg. For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486.

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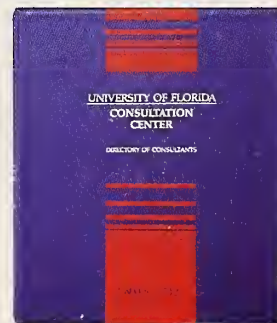
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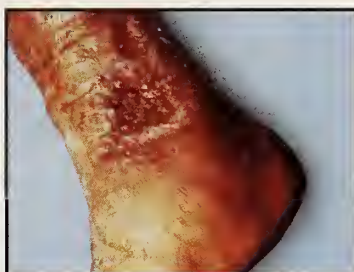
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**THE COVER**

"Open Heart Surgery-A," by Lamar Dodd, introduces this issue of the *Journal* which features several articles on various kinds of surgical procedures. The painting is available in a limited edition print. Contact Dean Geiss at the American Heart Association, Georgia Affiliate, in Atlanta for further information, 404-952-1316. Read more about Lamar Dodd on p. 127.

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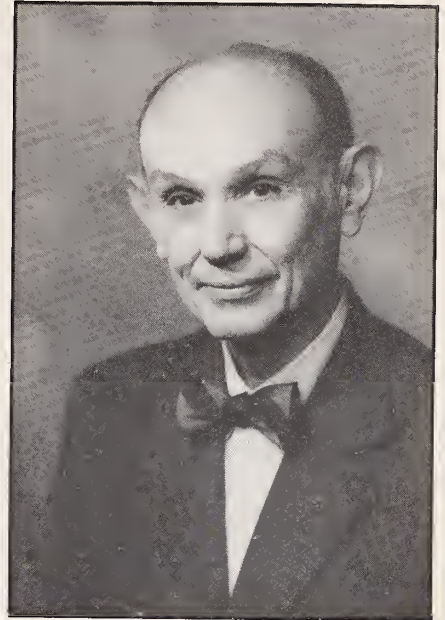
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**G**aMPAC works on behalf of the entire medical profession; *every* member of the medical community benefits from GaMPAC's success. Decisions made within the political arena have a significant impact on your daily practice management. It is essential that you have an effective voice in influencing the outcome of those decisions. Joining GaMPAC gives you, the individual, that voice.

Do not fail to take advantage of this opportunity to influence our future! Please contact Mrs. Donna Glass at 1-800-282-0224 at MAG Headquarters to establish your GaMPAC membership.

*Joseph P. Bailey, Jr.*

## NEW MEMBERS

Abernethy, Don L., Jr. — Bibb —  
(Student) Mercer University  
School of Medicine, 1550  
College St., Box #1, Macon  
31207

Amett, John D. — Bibb —  
(Student) Douglas 31533

Baldwin, Patrick S. — Bibb —  
(Student) Mercer University  
School of Medicine, 1150  
College St., Box #4, Macon  
31207

Bartlett, Maria H., Cardiology/  
Internal Med. — Bibb —  
(Active N2) 330 Hospital Dr.,  
Ste. 304, Macon 31213

Beacham, Eleanor M — Bibb —  
(Student) 3876 Northside Dr.,  
Apt. A1, Macon 31210

Christian, Martin C. — Bibb —  
(Student) Mercer University  
School of Medicine, 1550  
College St., Box #31, Macon  
31207

Clark, Alan D., Emergency  
Medicine — Richmond —  
(Active) Emergency Services  
HA-107, Medical College of  
Georgia, Augusta 30912

Coates, Griffin R., General Surgery  
— Whitfield-Murray (Active N1)  
1107 Broadrick Dr., Dalton  
30720

Critz, Frank A., Therapeutic  
Radiology — DeKalb —  
(Active) P.O. Box 8120, Atlanta  
30306

DeMarco, Bryan J., Obstetrics &  
Gynecology — Cobb — (Active  
N2) 1790 Mulkey Rd., Austell  
30001

Derveloy, Robert J., III,  
Cardiovascular & Thoracic  
Surgery — Muscogee — (Active  
N2) Physicians Bldg., Ste. 201,  
Columbus 31901

Dockery, Jeffery J. — Bibb —  
(Student) 3535 Williamson Rd.,  
Apt. 301-C, Macon 31206

Ellis, Howard — Bibb —  
(Student) 1810 Winship St., Apt.  
4-H, Macon 31204

Eades, Jack R. — Bibb —  
(Student) 1810 Winship St., Apt.  
2, Macon 31204

Fine, Richard E., Surgery &  
Disease of Breast — Cobb —  
(Active N2) 702 Cherokee,  
Marietta 30060

Haliczer, Abe T., Anesthesiology  
— MAA — (Active N2) 3450  
Jones Mill Rd., #217, Atlanta  
30338

Hammen, Patrick F. — Bibb —  
(Student) Mercer University  
School of Medicine, 1550  
College St., Box #15, Macon  
31207

Heine, David W., Internal  
Medicine — Glynn — (Active  
N2) 3215 Shrine Rd., Brunswick  
31520

Henslee, Steven L.,  
Ophthalmology — Muscogee —  
(Active) 623 Talbotton Rd.,  
Columbus 31904

Hightower, Richard R., Jr. — Bibb  
— (Student) 347 College St.,  
Apt. 6-D, Macon 31210

Hoddeson, Robert B.,  
Otolaryngology — DeKalb —  
(Active) 484 Irvin Court, Ste.  
140, Decatur 30030

Hodges, Stanley M. — Bibb —  
(Student) Mercer University  
School of Medicine, 1550  
College St., P.O. Box 19, Macon  
31207

Holley, Jeff N. — Bibb —  
(Student) Mercer University  
School of Medicine, P.O. Box  
20, Macon 31207

Hueseman, Linda M. — Bibb —  
(Student) Mercer University  
School of Medicine, Box 21,  
Macon 31207

Jackson, Melvin — Bibb —  
(Student) 2863 Flewellyn Dr.,  
Macon 31201

Jester, Mark A., Internal Medicine  
— Floyd-Polk-Chattooga —  
(Active N1) 7 John Maddox,  
Rome 30161

Koontz, William L., Obstetrics/  
Gynecology — Bibb — (Active)  
777 Hemlock St., Macon 31201

Lawson, David L., Internal  
Medicine — Glynn — (Active  
N2) 2 Medical Tower, 3215  
Shrine Rd., Brunswick 31520

Mangum, Michael D., Internal  
Medicine/Hematology/Oncology  
— Bibb — (Active N2) 729 Pine  
St., Macon 31201

Mapp, Samuel E. — Bibb —  
(Student) 1923 Edemas St., Apt.  
#5, Macon 31204

Mayville, Christina L. — Bibb —  
(Student) 4501 Sheraton Dr.,  
Apt. #226, Macon 31210

McLeod, Michael D. — Bibb —  
(Student) 4501 Sheraton Dr.,  
#338, Macon 31210

Mercer, Alicia R. — Bibb —  
(Student) 1962 Winship St.,  
Macon 31204

Moore, Charles M., Emergency  
Medicine — Cobb — (Active  
N2) 1645 Pinefield Rd., Marietta  
30066



Mucha, T. Edgardo, Cardiology —  
Richmond — (Active) 3614-B  
J. Dewey Gray Cir., Augusta  
30909

Nunnemann, Rudolf G., Urology  
— Glynn — (Active) 3104  
Shrine Rd., Brunswick 31523

Otto, Katharine C. — Bibb —  
(Student) 1005 College St., #1,  
Macon 31201

Patel, Narendra M., Internal  
Medicine & Gastroenterology —  
Whitfield-Murray — (Active N2)

Paul, Stephen E., Neurosurgery —  
Glynn — (Active) 3215 Shrine  
Rd., Brunswick 31520

Paynter, Steven W., General  
Surgery — Whitfield-Murray —  
(Active N2) P.O. Box 1969,  
Dalton 30722

Petrosky, Michael, Plastic &  
Reconstructive Surgery — Cobb  
— (Active N2) 11685 Alpharetta  
Hwy., Ste. 360, Roswell 30076

Price, Thomas W., Internal  
Medicine — Bibb — (Active  
N2) 330 Hospital Dr., Macon  
31213

Prinsell, Jeffrey R., Oral &  
Maxillofacial Surgery — Cobb  
— (Active N2) 200 Galleria  
Pky., NW, Ste. 1710, Atlanta  
30339

Qazi, Mohammad H.A., 3701 Old  
Dawson Rd., Albany 31707

Ragan, Bil L. — Bibb — (Student)  
2663 Hwy. 41 South, Perry  
31069

Raines, Marcus E., Internal  
Medicine — Ware — (Active  
N2) 1921 Alice St., Waycross  
31501

Ranno, Nicholas S.,  
Anesthesiology — Cobb —  
(Active) 759 Terrell Crossing,  
Marietta 30067

Reddy, Swaroop M., Pediatrics —  
Ogeechee River — (Active N2)  
404 Savannah Ave., P.O. Box  
488, Statesboro 30458

Reeves, Kenneth W., Cardiology  
— Richmond — (Active) 3614  
J. Dewey Gray Circle, Augusta  
30909

Rosenstein, Byron D.,  
Orthopaedic Surgery — Cobb  
— (Active N2) 3903 South Cobb  
Dr., Ste. 101, Smyrna 30080

Salmon, Joni K. — Bibb —  
(Student) Mercer University  
School of Medicine, 1550  
College St., Box 51, Macon  
31207

Santiago, Dina A. — Bibb —  
(Student) 29-F Tidewater Circle,  
Macon 31211

Scheetz, Allison P. — Bibb —  
(Student) 6-F Tidewater Circle,  
Macon 31211

Sewell, Alvin D., Anesthesiology  
— Bibb — (Active N2) 777  
Hemlock St., Macon 31201

Shankar, Talla P., General Surgery  
— Clayton-Fayette — (Active)  
6564 Professional Place,  
Riverdale 30274

Shivers, William F., Jr., Psychiatry  
— Glynn — (Active) 300 Main  
St., Ste. 202, St. Simons Island  
31522

Spiller, Paul C. — Bibb (Student)  
951 Park Place, Macon 31201

Stager, Peter J. — Bibb —  
(Student) 183 DeSoto Place,  
Macon 31204

Steinbook, Michael N.,  
Gastroenterology — Muscogee  
— (Service) 5382 Pine Needle  
Dr., Columbus 31907

Stovall, Raymond L., Internal  
Medicine — Gwinnett-Forsyth  
— (Active) 100 Medical Center  
Blvd., Lawrenceville 30245

Taylor, Kevin — Bibb — (Student)  
2997 Ridge Ave., Apt. #7,  
Macon 31204

Thornton, John W., Cardiology —  
Richmond — (Active) 818 St.  
Sebastian Way, Ste. 304,  
Augusta 30901

Ulrich, Wesley D., General  
Practice — Peachbelt —  
(Active) 216 Corder Rd., Warner  
Robins 31088

Vick, James H., III — Bibb —  
(Student) 100 Coppergate Lane,  
Macon 31211

Wade, Robert S., Pediatrics —  
Whitfield-Murray — (Active)  
1500 Dug Gap Rd., Dalton  
30720

Walden, Linda I. — Bibb —  
(Student) P.O. Box 6673, Macon  
31208

Warner, Amy S., Internal Medicine  
— Coweta — (Active N2) 300  
Prime Point, Peachtree City  
30269

Warner, Robert C., Cardiology —  
Cobb — (Active N2) 1001  
Thornton Rd., Box #8, Lithia  
Springs 30057

Weber, Warren M., Internal  
Medicine — Cobb — (Active)  
150 Plaza Way, Ste. E, Marietta  
30060

Williams, John E., Anesthesiology  
— Muscogee — (Active N2)  
3439 Hilton Woods Dr.,  
Columbus 31904

Wilson, J. Alan — Bibb —  
(Student) Mercer University  
School of Medicine, Box #47,  
Macon 31207

Wizner, Christopher R. — Bibb —  
(Student) 1962 Winship St., Apt.  
#8, Macon 31201

Woods, Deidra R., Internal  
Medicine & Geriatrics —  
Sumter — (Active) 629 East  
Forsyth, Americus 31709

Zwiren, Jeffrey D., Plastic Surgery  
— Gwinnett-Forsyth — (Active  
N2) 100 Medical Center Blvd.,  
#255, Lawrenceville 30245

## PERSONALS

### *Ben Hill-Irwin CMS*

**Ralph Roberts, M.D.**, of  
Fitzgerald, was recently honored  
as the first recipient of Dorminy  
Medical Center's Collins/Johnson  
Sterling Care Award. The award  
was given for his dedicated care  
to the employees of the medical  
center.

### *Georgia Medical Society*

The Georgia Medical Society  
recently elected a new slate of  
officers including **Frank E.  
Carlton, M.D.**, as president, and  
**Robert D. Gongaware, M.D.**, as  
president-elect. Other officers  
elected and installed were  
**Anthony M. Costrini, M.D.**, vice  
president; **Michael Zoller, M.D.**,  
secretary; **C. Lamont Osteen,  
M.D.**, treasurer; and **A. Preston  
Russell, M.D.**, historian.

**J. Patrick Evans, M.D.**, was  
elected to the Medical Association  
of Georgia's board of directors,  
and **Roland S. Summers, M.D.**,  
was elected alternate director.

### *Gwinnett-Forsyth CMS*

**Ralph A. Tillman, M.D.**, of  
Norcross, was appointed last  
November to the Board of

Director's of the Gwinnett  
Hospital Authority. He is the first  
physician ever to be appointed to  
this Board.

### *Colquitt CMS*

**Nancy Lafuente, M.D.**, of  
Moultrie, has been named a  
fellow of the American Academy  
of Family Physicians.

### *Medical Association of Atlanta*

**Robert F. Finegan, M.D.**, an  
anesthesiologist from East Point,  
received the Crawford W. Long  
Distinguished Service Award by  
the Georgia Society of  
Anesthesiologists.

Dr. Finegan, a charter medical  
staff member of the South Fulton  
Medical Center, has served as  
both Chief of Anesthesiology and  
Chief of Staff. He has been active  
on numerous committees within  
the Georgia Society of  
Anesthesiologists.

Considered to be the  
"Grandfather of CPR" in Georgia,  
Dr. Finegan was on the first  
American Heart Association  
committee for CPR in 1966 and  
has remained active to promote  
the CPR program throughout the  
state.

Dr. Finegan graduated from the  
Northwestern University Medical  
School and completed his  
internship and residency  
programs at St. Francis Hospital  
in Evanston, Illinois.

### *South Georgia CMS*

**David W. Retterbush, M.D.**, of  
Valdosta, has been awarded  
fellowship in the American  
College of Surgeons.

### *Spalding CMS*

**Abraham Oshlag, M.D.**, a  
retired internist, and **Ann  
Stuckey, M.D.**, a pediatrician,  
were recently awarded the  
Distinguished Service Award by

the Spalding County Medical  
Society. Dr. Oshlag and Dr.  
Stuckey, husband and wife, have  
82 years of combined service  
between them to their patients  
and to the community.

## OTHER NEWS

### **Diabetic Volunteers Needed**

Emory Clinic in Atlanta is  
looking for non-insulin dependent  
diabetic volunteers (40-70 years  
old) for a drug study which will  
assess insulin sensitivity using an  
FDA approved oral medication.  
Multiple visits to the clinic over a  
5-month period will be required.  
All medications and support  
services for the study are  
provided. Call Suzanne Gebhart,  
M.D., or Rene Guild, R.N., at 404-  
321-0111, Ext. 4528, for more  
information.

### **HCFA Agreement Regarding Medically Unnecessary Program**

HCFA and the AMA have agreed  
on some changes that HCFA will  
make in the medically  
unnecessary program as a result  
of AMA's threatened litigation.  
These changes include (1) a  
required process for medical  
society notice and consultation  
on carrier issues and (2) the  
formal release of all screens  
(parameters) is not required at  
this time but input from medical  
societies regarding new screens is  
required, and consultation  
regarding any carrier policy is  
mandated.

AMA will assist any state  
medical society in the process of  
responding to, and consulting  
with, any carrier regarding  
medical review policy.

For more information, contact  
Cam Taylor at MAG Headquarters,  
404-876-7535 or 800-282-0224.



# Lillie Davis Isn't Ready For a Nursing Home

Lillie Davis loves life. She has always been active and independent. However, sometimes being over 65 means she can't lift heavy groceries or keep up the yard as she once

did. Occasionally medical problems mean she needs assistance, not at a hospital, and certainly not a nursing home, still a little help. Huntcliff Summit is a caring and affordable alternative to receiving help at home or at

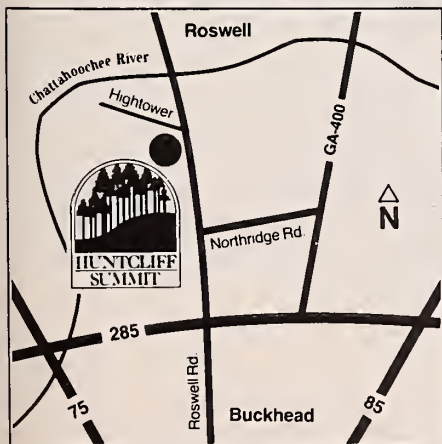
your children's home. Huntcliff Summit allows Lillie Davis to have her independence to be as active as she can be, while having 24 hour nursing personnel available, medicine supervision and delicious meals every day. Find independence with care and love at Atlanta's New Standard for independent living, Huntcliff Summit.



Our 24 hour staff is here to serve your needs.



Maid and linen services give you time for activities or rest.



Huntcliff Summit is centrally located near Dunwoody, Sandy Springs, and Roswell. Northside, Shallowford, and St. Joseph's hospitals are minutes away.

Send me more information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Zip \_\_\_\_\_

Phone \_\_\_\_\_



8592 Roswell Road  
Atlanta, GA 30350  
(404) 552-3050





## Another Blow to Medicaid

Despite hospitals' already tight Medicaid payments, the governor's budget recommendations to the Georgia General Assembly bypassed the requests of the Department of Medical Assistants for Medicaid improvements. The denial of the DMA requests is part of an effort to put the state budget within the revenues expected from current taxes. Estimates are that the continuation of the present Medicaid program and expansions in the state employee health plans will cost \$148 million and \$75 million, respectively, and those items together will make up slightly more than half of the \$438 million available for improvements in FY 1990.

In denying the DMA's requests, the proposed budget gave no recommendation for any of the following:

- no recommendation to expand Medicaid eligibility;
- no recommendation for a swing bed program for small rural hospitals;
- no recommendation for preadmission review, which would end the cap on hospitals' Medicaid admissions;
- no recommendation to restore the full intensity factor for disproportionate share hospitals; and
- no recommendation for a rate increase in hospitals' Medicaid reimbursement. If the legislature accepts this provision, hospitals' Medicaid rates will continue to be based on the 1987 cost report, and Georgia Hospital Association estimates that the result will be a 10% to 15% cut in hospitals' Medicaid reimbursement for 1990.

## Medicare Faces \$6 Billion Reduction

News for Medicare isn't good. Under a proposal agreed on by the

Department of Health and Human Services and the Office of Management and Budget, Medicare would see a \$6 million reduction in fiscal year 1990, with more than half of that amount coming from hospitals' DRG reimbursement and capital payments for the indirect teaching adjustment.

Specifically, the proposal would do the following:

- limit the annual DRG update factor to the rate of increase in the hospital marketbasket less 2.5%;
- reduce Medicare's capital payments to cost minimum 18%; and
- cut the indirect medical education payment adjustment almost in half, from 7.7% to 4.05%.

The proposal would also cut physicians' Medicare payments by nearly \$1 billion. Part B payments would see cuts in reimbursement for certain procedures, a reduction in increases for physicians' payments in general, and lower payments for radiology and anesthesiology services.

And finally, for yet another \$2.5 billion savings, a second proposal calls for a 10% cut in hospitals' outpatient payments over a 3-year period beginning in fiscal year 1991.

## Taking a Second Look at Hospital Costs

Refuting allegations that hospitals are at fault for the continued rise in health care costs, the American Hospital Association (AHA) has released data showing that hospital expenses have remained flat since 1982 — 4.3% of the gross national product.

In addition, the AHA points out that hospitals' Medicare payments have been on the decline for the past 9 years. In 1980, a total of 73% of all Medicare payments went to hospitals; yet in 1988, only 65% of Medicare payments went to hospitals.

The public, says the AHA, needs to reexamine its preoccupation with regulating hospitals, because hospitals are not consuming an ever-increasing share of national resources.

## OBRA Restricts Nursing Home Admissions

Hospitals are seeing some far-reaching effects of the Omnibus Budget Reconciliation Act (OBRA) of 1987 in severe restrictions on nursing home admissions.

Under the provisions of OBRA, effective January 1, a mentally ill or retarded patient cannot be admitted to a nursing home unless that patient requires the 24-hour physical care that a nursing home provides.

Though that portion of the law was brought about by advocates for the rights of mental patients, the outcome has backfired on the advocacy groups. According to the Georgia Hospital Association, the result will be that many mental patients won't be able to find any type of care at all. In Georgia, an estimated 3,600 patients will be denied nursing home admission.

Under the provisions of the law, every patient bound for a nursing home must now be reviewed to determine whether that patient is mentally ill or retarded. Original plans were that the review could only be carried out by state officials; however, as a result of the hospital association's intervention, hospital personnel will now be able to assist in the review and hopefully eliminate the potential admission delays the total state review could create.

*(This page is sponsored by the Georgia Hospital Association.)*



## Walking Through The Valley

***“We thought of the blood bathing our hands. We thought of the medical decision making by legislators — of the politization of epidemics.”***

*“Yea, though I walk through the valley of the shadow of death, I will fear no evil.”*

**I**T WAS A COLD and blustery night. Cold and blustery and raining, lending to the night that sense of loneliness one usually tries to avoid. The two of them, truck drivers both, had stopped the big rigs, all 18 wheels of them, on the outskirts of the city for a few hours rest. The last stop had been a distance back down the road. Why not a few beers? Why not a few hours of relaxation with the boys at a local tavern? The early evening slipped into late night before time to leave arrived. They wandered through the mist and across the highway with little thought to traffic. The impact came suddenly. Two bodies hurdled through the air, smashed into the asphalt, and rolled to the gutter as the sports car disappeared in the fog.

They brought them to the emergency room, one more critical than the other. He was a large man, big and burly with muscles bulging through a tight fitting shirt. Short and stubby fingers on thick hands. Nails close worn and cluttered. He lay unconscious, bruised, and battered with wide fixed pupils and a tender expanding abdomen. The tattoos seemed appropriate to the setting. “Love — Mother” on the one arm and “Love — Billy” on the other.

**W**e paid little attention to the tattoos. He was from a distant city. No family at once available. No need for family now. The indications to proceed, and hastily, with exploration of the abdomen were clear.

We spent the better part of the early morning hours in a desperate effort to control the bleeding. Blood everywhere — soaking through gowns, bathing hands through unseen or unsuspected failure of gloves. Surgeons, nurses, all of us there through the night. It was over at last. He had survived.

Several days passed following that night. His life hung in a delicate balance. Still no family, and then some days later came the word that the wife was on the phone. She seemed rather uninterested. He had left home some time ago, she said, and was “living with” a male friend. He had a history of such a lifestyle, she said.

We thought back. The tattoo, “Billy” stood forth more clearly now. It seemed to carry a message. Unusual, we thought, on this “masculine” man. We thought of the blood bathing our hands. We thought of the medical decision making by legislators — of the politization of epidemics. We seemed to have walked through the valley of the shadow of death.

CRU

# Quiet Thoughts

*From Bynum's Scrap-Book:*

## THE SURGEON'S HANDS

His face? I know not whether it be fair,  
Or lined and grayed to mark the slipping years.  
His eyes? I do not glimpse the pity there.  
Or try to probe their depths for hopes or fears;  
Only upon his wondrous hands I gaze,  
And search my memory through so flittingly  
To voice their loveliness. In still amaze,  
I bow before their quiet dignity.  
They make the crooked straight and heal old sores;  
The blind to see, the War-Torn clean and whole.  
Throughout the suffering world, they touch the doors  
That open wide to life. The bitter bowl  
Of pain they sweeten 'till the weary rest,  
As though the hands of Christ had served and blest.

IDA NORTON MUNSUN

## LOST LEAVE — 1943

Dear Matthew;

I only saw your telegram just now!  
Six hours of leave for you — And Oh, my dear,  
I must confess I spent them with a stranger  
Who so consumed my body, heart, and mind  
That I am weak and breathless with great living.  
And with the telling of this news to you,  
My heart pleads your forgiveness and blessing  
And hope, that in the kindness of your soul,  
You'll find that you can share a part of Me  
To one I hold most dear in every way.  
He weighs nine pounds — We named him Matthew James.  
My Dear, your son was born at noon today!!

RICHARD BYNUM WEEKS, M.D.

*We invite contributions to this Department. Please send them c/o the Journal,  
938 Peachtree St., Atlanta 30309.*



# Lamar Dodd

**O**UR COVER ART this month is "Open Heart Surgery-A," an exquisite interpretation by Lamar Dodd, Chairman Emeritus of the Art Department at the University of Georgia in Athens. Anyone who has been associated with heart surgery will appreciate this sensitive portrayal of life in the balance.

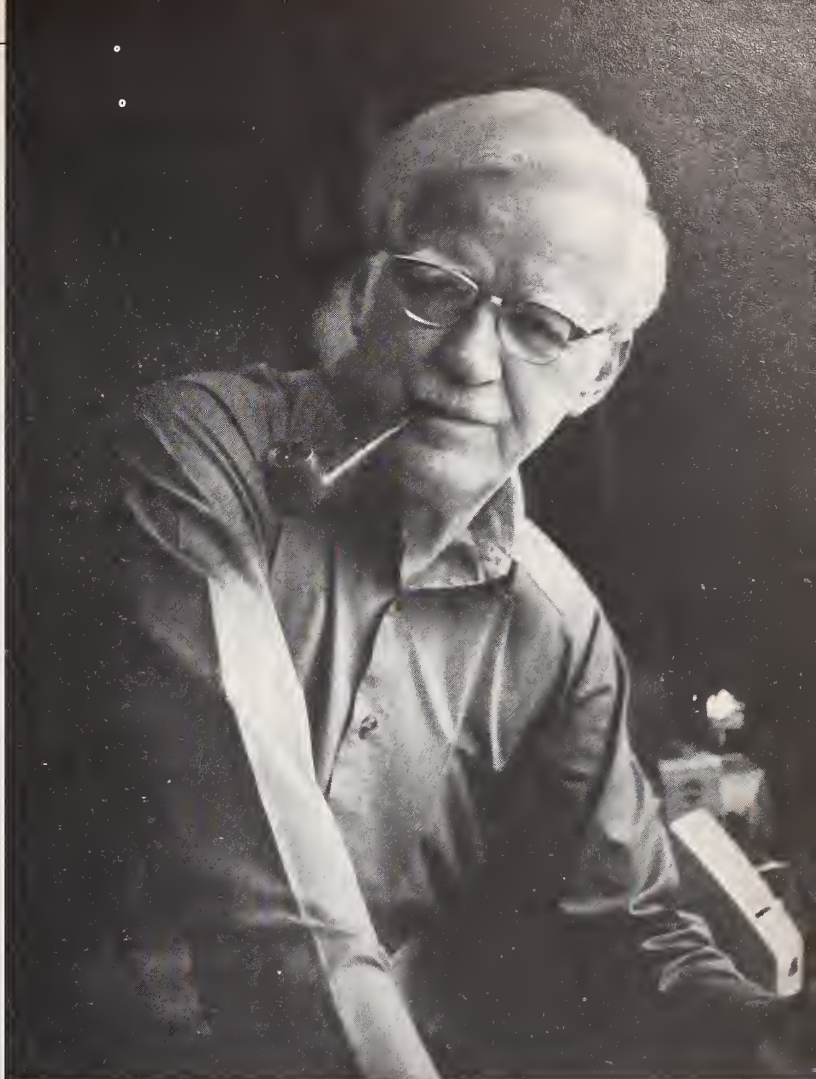
This is one of a series of paintings by Mr. Dodd that was done after his wife Mary's heart surgery in 1977. When asked if this series of paintings were about her surgery, he said, "I must say both 'no and yes' in some degree." Some time after his wife's operation, he had observed her surgeon, Dr. Joe Craver, of LaGrange, perform another heart operation. He remarked, "After being in surgery for three or four hours, I thought to myself that this was amazing: a man's heart had been stopped and started — a man was alive, then dead, then alive again. It's not normal to witness such renewal of life and I had to pinch myself to make sure that I was still alive. During this time, I really did not think about whether this was how he operated on Mary; I did not relate it to Mary's experience.

"From that beginning, the door to this medical world opened up more and more, and I became very concerned about heart surgery. My interest was not strictly scientific. By studying charts I increasingly identified many comparisons between these diagrams and forms in nature. I found universal forms in these charts."<sup>1</sup>

## Permanent Collections:

Mr. Dodd's work is in many private and public collections, including:

Birmingham Museum of Art  
Columbus Museum of Arts and Crafts, Inc. (Georgia)  
Freer Gallery, Smithsonian Institution (NASA paintings)  
Georgia Heart Clinic, LaGrange, with 45-piece collection of working drawings, pastels and oil paintings of "The Heart" series acquired by the Callaway Foundation, custodianship Lamar Dodd Art Center.  
Georgia Museum of Art  
Hallmark Collection  
High Museum of Art, "South Carolina Coast," oil; "Foot of Blackhead," watercolor  
IBM Corporation, "Drying Out"  
LaGrange College, LaGrange, Georgia  
Lamar Dodd Art Center, LaGrange, Georgia  
Metropolitan Museum of Art, "Sand, Sea and Sky" and "Monhegan Theme"



Montclair Art Museum, "Savannah"  
Montgomery Museum of Fine Arts  
National Academy of Design  
National Aeronautics and Space Administration, Washington, D.C.  
National Collection of Fine Arts  
National Gallery of Art, "Winter Valley"  
Pennsylvania Academy of Fine Arts  
Telfair Academy, Savannah, "Carnival"  
University of Notre Dame Art Gallery  
Valdosta State College, Valdosta, Georgia  
Virginia Museum of Fine Arts, "Winter Road"  
Whitney Museum of American Art

**A** special lithographic reproduction of "Open Heart Surgery-A" is available from the American Heart Association through the generosity of Mr. Dodd in both limited and signed editions. Each limited edition print is signed and numbered by the artist, mounted and matted; only 200 have been produced. Signed, unnumbered prints are also available; these will be shipped ready to mount.

Produced as a special project to benefit the American Heart Association (AHA) Georgia Affiliate, it is suggested that 75% of the cost of either print may be considered as a charitable contribution. For further information or to order a print, contact Mr. Dean Geiss at the AHA, Georgia Affiliate, in Atlanta, 404-952-1316.

1. Georgia Museum of Art. Lamar Dodd, The Heart. Univ. of GA, Athens.



# CALENDAR

## MARCH

28-29 — *Macon: Cherry Blossom Days of Perinatology.* AMA Category 1 credit and AAFP prescribed credits. Robert C. Fore, Ed.D., Medical Center of Central GA, Mercer Univ. Sch. of Med., Macon 31208. PH: 912/744-1634.

29-Apr. 1 — *Pine Mountain: Eighth Annual Geriatrics Conference.* AMA Category 1 credit and AAFP prescribed credits. Contact Helen Peterson, The Medical Center, 710 Center St., Columbus 31994. PH: 404/571-1145.

29-Apr 2 — *Tucson, AZ: Eleventh Annual Pediatric Postgraduate Course, Pediatrics in Review, "Birth to Adolescence."* Category 1 credit, PREP credits, & prescribed AAFP. Contact Janice Cavanaugh or Darlene Baugus, Education Dept., Scottish Rite Children's Hosp., 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/257-2148.

30-Apr 1 — *Atlanta: Technical Innovations in Neoplastic Surgery.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## APRIL

3-7 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

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29-30 — *Atlanta: The Cardiac Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MAY

1-6 — *Augusta: 24th Annual Primary Care and Family Practice Symposium.* AMA Category 1 credits and AAFP Prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

4 — *Atlanta: Soberfest Conference, "Alcohol and Drug Abuse: A Day with the Experts."* Category 1 credit. Contact Susan E. Pajari, Willingway Hospital, 311 Jones Mill Rd., Statesboro 30458. PH: 912/764-6236.

4-7 — *Atlanta: 135th MAG House of Delegates.* Contact Lynn Pearson, MAG, 938 Peachtree St., Atlanta 30309. PH: 800/282-0224 or 404/876-7535.

5 — *Statesboro: Soberfest Conference, "Alcohol and Drug Abuse: A Day with the Experts."* Category 1 credit. Contact Susan E. Pajari, Willingway Hospital, 311 Jones Mill Rd., Statesboro 30458. PH: 912/764-6236.

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19-21 — *Destin, FL: Georgia Radiological Society Annual Meeting.* Category 1 credit. Contact Lloyd B. Schnuck, Jr., M.D., 9 Medical Arts Center, Savannah 31405. PH: 912/242-8090.

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**Summary.**  
Consult the package literature for prescribing information.

**Indication:** Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci).

**Contraindication:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.  
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

**Precautions:**

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

**Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

**Abnormalities in laboratory results of uncertain etiology**

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

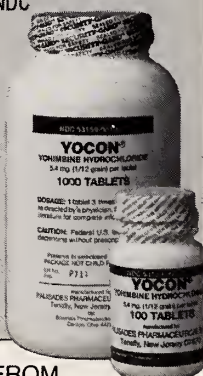
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## (sucralfate) Tablets

#### BRIEF SUMMARY

#### CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

#### PRECAUTIONS

Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

**Pregnancy:** Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

#### OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

#### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

#### HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

#### Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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**EDUCATION** Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

**RESIDENCY** Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

**FELLOWSHIP** First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

**OUTSTANDING ACHIEVEMENTS** Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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# Evolution and Current Status of Surgery for Morbid Obesity: Part II

William M. Headley, M.D., F.A.C.S., Joyce C. Headley, R.N., P.A.

## Introduction

**L**AST MONTH'S *Journal* featured Part I of the "Evolution and Current Status of Surgery for Morbid Obesity." That article reviewed our current knowledge of the incidence and causes of morbid obesity, its medical consequences, and the great difficulty of treating obesity with diet and behavior modification.

Clinical trials show little or no long-term weight loss from non-surgical approaches for the morbidly obese. Surgical weight-loss procedures are finding increased favor as evidence accumulates that they produce loss of between 60 percent of excess weight lasting for at least 5 to 10 years in appropriately selected subjects.

Jejunioleal bypass, a malabsorption procedure, though effective for weight loss, has been virtually abandoned because of its high rate of complications. Gastric bypass, a calorie-restriction procedure, allows the patient to eat only very small amounts of food. It produces weight loss equal to that following

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**Vertical banded gastroplasty appears to be the safest procedure in the bariatric surgeon's repertoire at this time for the management of medical problems related to morbid obesity.**

---

intestinal bypass with much lower morbidity.

Vertical banded gastroplasty is the latest evolution of bariatric surgery. At the present time, it is considered by many bariatric surgeons to provide the optimal combination of ease of performance and satisfactory weight loss with a minimal complication rate.

In Part II, we will discuss how to choose the appropriate procedure for the individual patient based on data accumulated from the authors' experience. Also long-term follow up of the bariatric surgical patient will be discussed.

---

Dr. Headley specializes in general and bariatric surgery; Ms. Headley specializes in bariatric surgery. Both are affiliated with the Baldwin County Hospital in Milledgeville. Send reprints to Dr. Headley, at P.O. Box 656, Milledgeville, GA 31061.

## Outcome and Evaluation of Gastric Bypass vs. Vertical Banded Gastroplasty

In deciding which procedure to rely on more heavily — gastric bypass (GBP) or vertical banded gastroplasty (VBG) — several factors need to be considered.

Operative mortality for both procedures is one percent or less. Operative time for the GBP is 2 hours and for the VBG, 1 hour. Patients having the GBP require a nasogastric or gastrostomy tube, while none is used with the VBG. The wound complication rate is lower with the VBG.

Mason, et al<sup>1</sup> note that with the VBG, "Leaks, abscesses, peritonitis and death from deep infection have decreased about ten-fold from the earlier experience with the loop gastric bypass. The same order of magnitude reduction in wound infection has been observed. The VBG is inherently a safer operation."

Passage of food through its natural route in the VBG means that VBG patients avoid several problems inherent in GBP. With VBG,

there is less need for iron and Vitamin B12 supplements. GBP patients, on the other hand, can develop an iron deficiency anemia. Sixty percent or more of our GBP patients have low B12 at 3 to 4 years if they do not have B12 injections or oral supplements.

Since GBP may lead to restricted calcium absorption and possibly osteoporosis (although this con-

35 percent between 51 and 75 percent of their excess weight.

Weight loss with VBG is also substantial. Mason, et al<sup>1</sup> found an average weight loss among VBG patients of 72 percent of excess at 5 years. They noted that loss with VBG (60% of excess lost at 3 years) was slightly less than with Roux-en-Y gastric bypass (65% of excess lost at 3 years). Fox and Fox<sup>5</sup> reported

thirds of their patients lost at least 60 percent of excess weight and had maintained this loss at a 2 to 4 year follow up.

Among our 509 GBP patients who had not had a conversion procedure, such as intestinal bypass and conversion to a gastric bypass or conversion of a horizontal gastropasty to a gastric bypass, maximum weight loss occurred between 2 and 3 years after surgery, with an average of 80 percent of excess weight being lost (Figure 1). Male patients, who started with a greater percentage of excess weight (115%) than female patients (92%), had a slightly lower degree of weight loss, 72 percent. Both men and women largely maintained weight loss after 8 years of follow up.

Figure 2 shows weight loss in groups of male patients with various degrees of excess weight loss after operation. Patients in each group lost weight that more or less paralleled the weight loss of groups above and below that weight level.

Figure 3 shows weight loss in groups of female patients. In all cases, maximum weight loss occurred after 2 years, fell by approximately 70 percent of excess weight, and was maintained for 8 years after surgery.

Maximum weight loss with VBG also occurred at 2 years postoperatively, with a maximum loss of about 60 percent of excess weight (Figure 4). Our experience with VBG is shorter than with GBP, but at 3 years, weight loss appears to be maintained. Our male and female patients lost approximately the same fraction of excess weight.

Looking at the weight loss of VBG patients by sex and degree of initial excess weight, we see that the procedure is approximately equally effective for all patients. Figure 5 represents various groups of males and their weight loss. Figure 6 shows the similar weight loss in groups of females.

Figure 7 shows a direct comparison of weight loss among our GBP and VBG patients. To make the comparison more accurate, we have included only "pure" cases (no conversions) in which a measured 10 cc pouch was made. Both groups experienced the vast majority of total weight loss in the first year, but

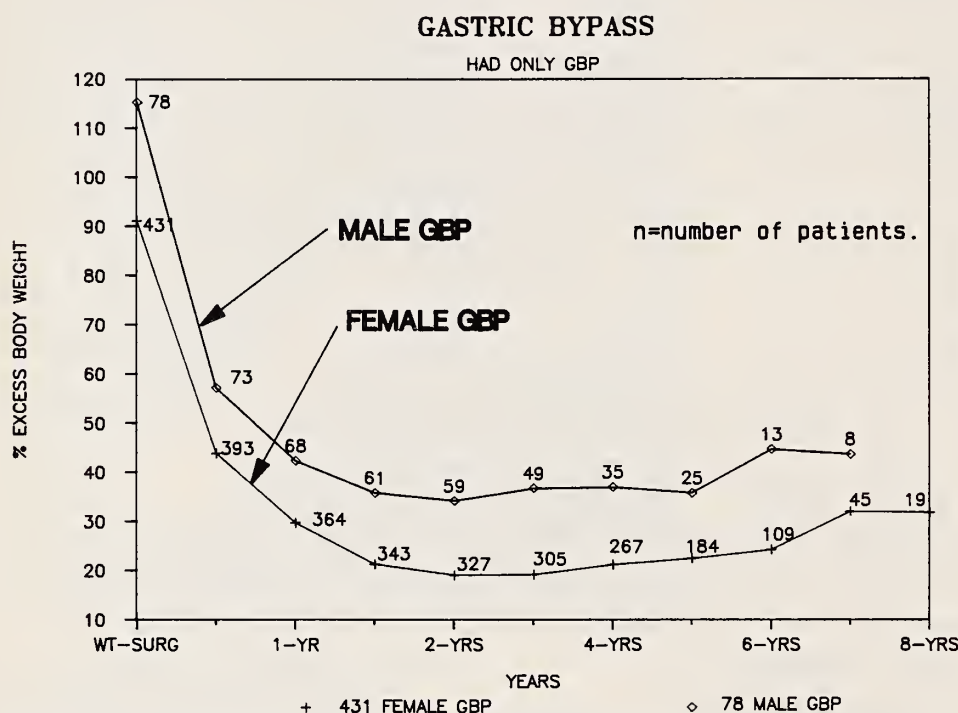


Figure 1: Percent of excess weight loss in male and female gastric bypass (GBP) patients.

nection has not been proven as yet), we recommend that GBP patients take several Tums each day. This is not thought to be necessary with the VBG patients. Bypassing the duodenum in GBP also exposes the patient to a low risk of peripheral neuropathy<sup>2</sup> and Wernicke-Korsakoff encephalopathy<sup>3</sup> if the pouch is too small. This complication has not been observed in our series.

One of the measures of success of these procedures is the degree of weight loss. An excellent weight-loss record among 223 patients receiving Roux-en-Y GBP was reported by Linner.<sup>4</sup> Patients lost an average of 74 percent of excess weight over ideal by 1 year and maintained or improved that loss over the next 3 years. About 55 percent of the patients lost at least 75 percent excess weight, and another

an average loss of 70-75 percent of excess weight at 18-24 months postoperatively.

Deitel, et al<sup>6</sup> defined a successful outcome as loss of at least 50 percent of excess weight. At 2 years after surgery, 83 percent of their patients had lost this much. Shamblin and Shamblin<sup>7</sup> reported that two-

**We are able to identify three factors as being important for the difference in weight loss between gastric bypass and vertical banded gastroplasty.**



GBP patients benefitted from a slightly greater weight loss in the second year after surgery. More importantly, first-year weight loss among GBP patients was greater than VBG patients. The net result is that GBP patients lost about 15 percent more excess weight than VBG patients. Regain so far is minimal in both groups.

**W**e are able to identify three factors as being important for the difference in weight loss between GBP and VBG. First, 30 to 50 percent of patients who have had a GBP experience a "dumping" syndrome from high carbohydrate intake. When large amounts of simple carbohydrates enter the small intestine, they "pull in" fluid, which leads to sweating, hypotension, light-headedness, tachycardia, and dizziness. Fear of the dumping syndrome creates a negative conditioning reflex to sweets.

Second, lactose intolerance can develop in GBP patients. Rather than being broken down by lactase in the stomach, lactose is fermented in the large intestine. This produces gas, causing cramping, diarrhea, and abdominal pain when the patient eats milk products. Thus, they tend not to eat ice cream or drink milk shakes.

Third, the quality of food intake may differ between the two procedures. The outlet of the VBG may be so small that red meat, for example, can't pass through it unless it is chewed quite thoroughly. The Marlex reinforcement prevents the outlet from enlarging, while the gastrojejunostomy of the GBP dilates by 3 to 5 years. As a result, GBP patients are more likely eventually to consume a better quality diet. Some people with a VBG resort to a vegetarian or seafood and chicken diet over time, but others increase their intake of high-calorie, low-nutritional value junk food, thereby partially defeating the purpose of the operation.

**H**aving made these comparisons between GBP and VBG, how do they help us decide which procedure to use? At the present time, we are doing the vertical banded gastroplasty as the primary operation in most patients. Some of the reasons for this are outlined above, including the fact that the

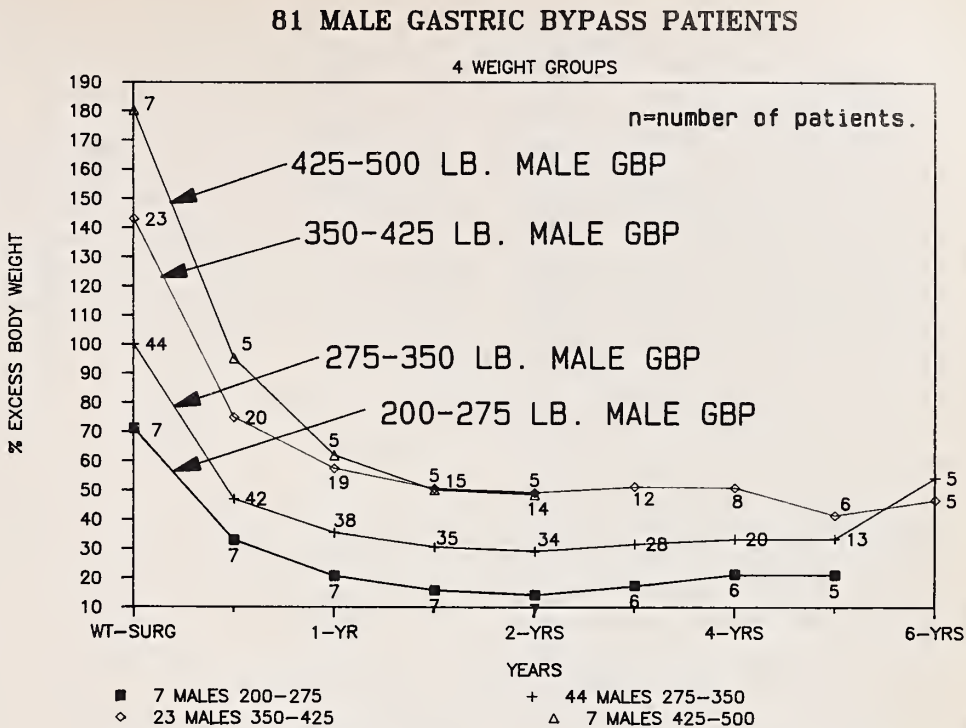


Figure 2: Weight loss in various weight groups of male gastric bypass (GBP) patients.

VBG is simpler and safer, and the weight loss is almost as good as the GBP without some of the sequelae that may occur with the GBP. As mentioned, the GBP is a much more difficult operation with an in-

creased instance of morbidity and possible mortality. Also, patients may have deficiencies of B12, iron, calcium, and some other nutrients, such as thiamine or folic acid, unless they take vitamins and other

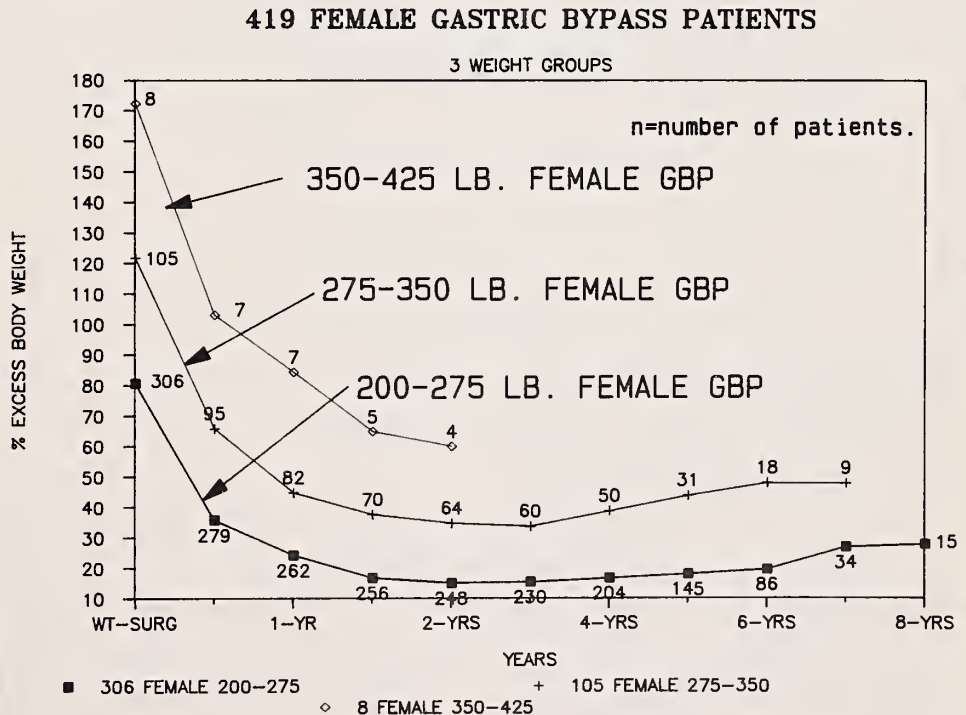


Figure 3: Weight loss in various weight groups of female gastric bypass (GBP) patients.

supplements regularly. It is very difficult to get many patients to take such medications faithfully over an extended period.

However, the most important consideration is that bariatric surgery is done primarily for health, not cosmetic reasons. There is general agreement that the initial weight loss is what produces the most dramatic changes in a patient's blood pressure, cholesterol, triglyceride levels, and improvement in orthopedic problems, as well as general well being. The ultimate 15 percent greater weight loss from the gastric bypass compared to the vertical banded gastroplasty would not seem to justify the increased potential risk and greater incidence of complications associated with the longer, more complicated GBP. As a result, we are increasingly encouraging patients to have the VBG.

A secondary factor that can influence the choice of procedure is whether or not the patient is a compulsive sweets eater. The effect of continual sweets was demonstrated by Sugarman, et al.<sup>8</sup> They randomized 40 patients to VBG or GBP with Roux-en-Y. At 1 year, there was a large and significant difference in percent of excess weight

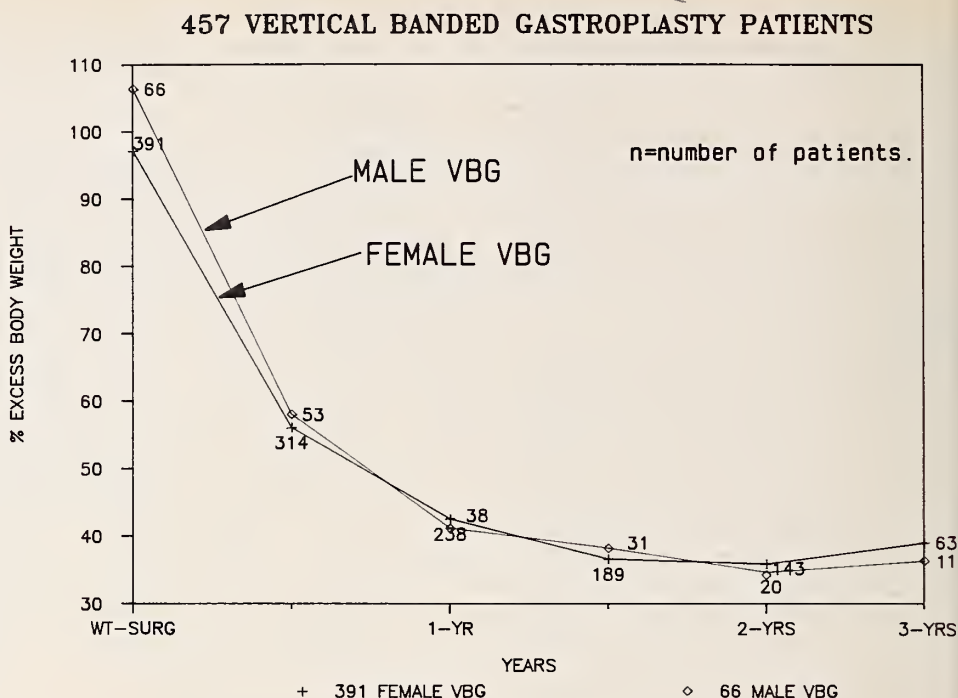


Figure 4: Comparison of weight loss in male and female vertical banded gastroplasty (VBG) patients.

lost between sweets eaters (36%) and non-sweets eaters (57%) having VBG, as well as between sweets eaters having VBG and those having GBP (69%).

There are definite indications for the GBP. For instance, it is difficult to convert the horizontal gastro-

plasty to a vertical banded gastroplasty. The gastric bypass lends itself much better to this revision. Also, when a gastric bypass has been done with too large a pouch, it is simpler and safer to revise the size of the pouch rather than convert it to a vertical banded gastroplasty. On the other hand, the VBG can be done readily in the same operative procedure when an intestinal bypass is taken down.

Occasionally, patients who have had the vertical banded gastroplasty will defeat the operation. The primary effect of either the GBP or the VBG is to prevent the patient from binge eating. Some VBG patients, however, ingest large amounts of high-calorie liquids, such as ice cream, alcoholic beverages, or candy. A VBG patient may defeat the operation by snacking throughout the day and evening. Such patients who have defeated the VBG are reasonable candidates for a revision. This is done by stapling shut the lower end of the pouch and converting the procedure to a lesser curvature gastric bypass with a distal Roux-en-Y anastomosis in which the jejunum is connected to the ileum about 4 feet from the ileocecal junction, thereby creating a partial malabsorptive procedure.

Whichever operation is chosen,

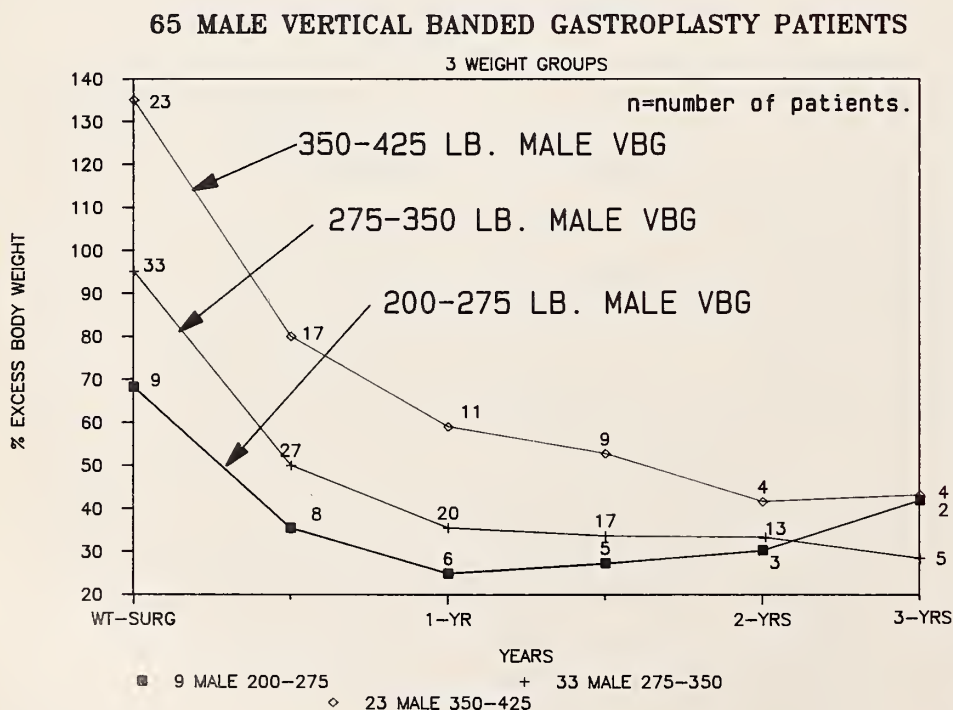


Figure 5: Weight loss in various weight groups of male vertical banded gastroplasty (VBG) patients.



we emphasize that neither the GBP nor the VBG is a magic procedure that works on its own. GBP and VBG are similar to each other, and different from JIB, in that both are behavior modification procedures. The pouch restricts the patient's intake, but the patient must be counseled that both gastric bypass and gastroplasty require their cooperation. Patients can rupture the staple line by eating or drinking too much after surgery. This occurs in less than 2% of patients.

In the end, the question is not which procedure is better, but which is better for an individual patient. In our presurgical videotape, the two operative procedures and our results are presented to the patients. For the most part, with the above exceptions, the VBG will be the operation of choice. A mother-daughter pair we operated on illustrates the decision process. The daughter was 28 years old, weighed 334 pounds and said she had no willpower. The mother was 50 years old, weighed 250 pounds, and thought she could control her sweets intake. The daughter chose a GBP, the mother a VBG.

### Long-term Follow-up of Bariatric Surgery Patients

Because long-term data are needed to evaluate various bariatric surgery procedures, we and others doing obesity surgery have attempted to follow as many of our patients as possible for as long as possible. Many of us are now contributing our data to the computerized National Bariatric Surgery Registry organized by Dr. Edward Mason at the University of Iowa.

In our practice we see patients 2 months after surgery, then at 6 months and 1 year. Following that, we try to maintain contact by mail and phone. We periodically send questionnaires which patients are asked to fill out and return. Data are entered into a computer file and updated frequently. At intervals, all patients on whom we have done bariatric surgery are invited to return to the Baldwin County Hospital for a Surgical Obesity Support (SOS) group meeting. We initiated formation of SOS groups in Georgia in 1973 and frequently attend regional

meetings to update our data, review our latest knowledge with patients, and answer their questions.

One of the frustrating outcomes of an obesity surgical operation is the need for conversion or revision. Different procedures have characteristic revision rates, from the 60 percent 5-year revision rate for the horizontal gastroplasty to 20 percent 5-year rate with Roux-en-Y gas-

tric bypass and the 2 percent 2-year rate with the VBG.

**W**e have performed about 140 revisions of our own and other surgeons' operations. These have primarily been conversions of horizontal gastroplasty done elsewhere to the gastric bypass, decreasing the size of the gastric pouch, or conversion of intestinal bypass to the GBP or — more often

### 384 FEMALE VERTICAL BANDED GASTROPLASTY PATIENTS

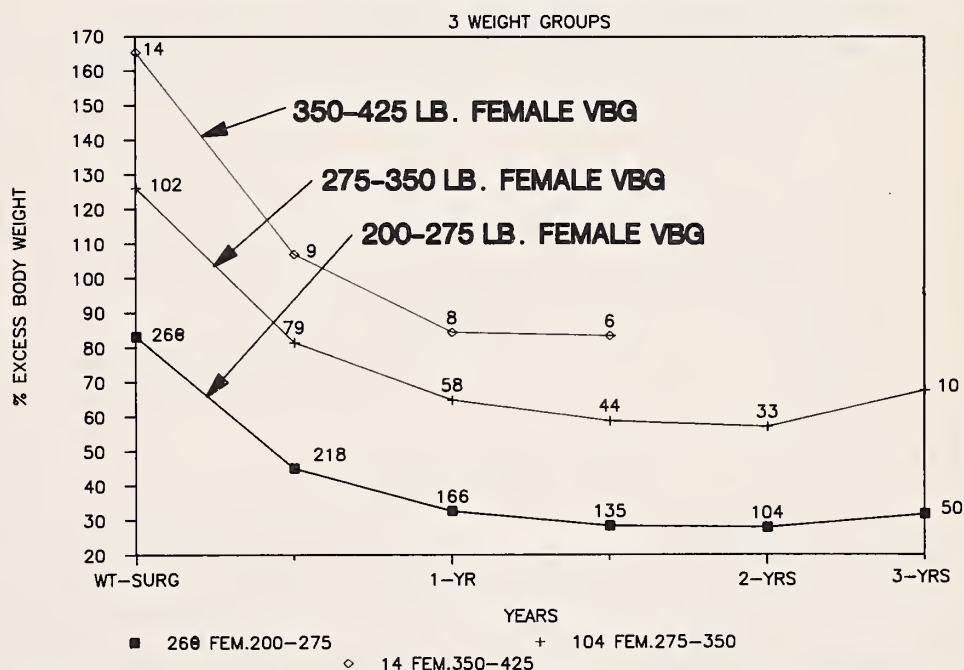


Figure 6: Weight loss in various weight groups of female vertical banded gastroplasty (VBG) patients.

**Whichever operation is chosen, we emphasize that neither the gastric bypass nor the vertical banded gastroplasty is a magic procedure that works on its own.**

— to the VBG. In Figures 8 and 9, weight loss following conversion to a GBP or a VBG is compared to weight loss in patients receiving the same procedure as their first bariatric operation. The data are most encouraging. Within a year, converted patients reach the maximal level of weight loss achieved by persons having their first bariatric procedure. They maintain this degree of weight loss as well as first-time subjects.

Revisions are necessary both because of procedural failures and

because of patients who are aggressive eaters. We have had patients with both GBP and the VBG who continued to eat too much and too fast and were throwing up. They asked for a takedown of the operation. Afterwards, they gained all the weight that they had lost.

We have seen a number of medical benefits from weight loss following obesity surgery. Ninety percent of patients taking insulin for their diabetes no longer required insulin after the surgery, and the other ten percent needed only a reduced dose. These same figures apply to patients taking antihypertensive drugs.

Clearing of severe dermatologic problems has also been observed. We performed gastric bypass on a

## The encouragement of a primary care physician is valuable to a patient attempting to regulate his or her eating patterns to get the greatest benefit from the surgery.

Only at times does it recur on her elbows.

Whether the improvement in medical conditions seen after bariatric surgery leads to a reduction

sion, and hyperlipidemia.<sup>9</sup> Reversal of benign intracranial hypertension has been reported in one patient following successful bariatric surgery.<sup>10</sup>

It is not clear whether these benefits translate into increased longevity. Van Itallie and Kral<sup>11</sup> have offered a model describing a theoretical decrease in cardiac mortality after weight loss. Recently, a decrease in cardiac mortality following bariatric surgery has been documented.<sup>12</sup>

**B**y following our patients after surgery, we were able to determine that about 15 percent of them had their gallbladders removed in the years after their bariatric operation. We now take out the gallbladder at the time of surgery in 44 percent of VBG patients. (Approximately 15 percent have already had it removed before surgery.)

To identify gallbladders that need removal, we check them for calculi at the time of surgery and for the appearance of cholesterosis as seen through the wall of the gallbladder. Bile aspiration has been done in about 200 patients and the bile analyzed for cholesterol and calcium bilirubinate. The gallbladders with a high level of calcium bilirubinate are more likely to need removal, but this approach has not been especially helpful in the decision on the individual patient. In 360 patients having gallbladder removed concomitantly with obesity surgery, we have had no complications of cholecystectomy and no extra hospital days because of the added surgery.

Severely obese women have abnormal sex hormone levels, due to their massive amounts of adipose tissue. Weight loss following bariatric surgery has been found to improve morbidly obese females' clinical gynecologic problems, in many cases with normalization of sex hormones.<sup>13</sup> Patients are encouraged not to get pregnant until after their weight has stabilized. Despite these warnings, however, many patients become pregnant soon after surgery. Printen and Scott<sup>14</sup> traced pregnancies in 45 female patients following obesity surgery. They found no increased incidence of pregnancy problems.

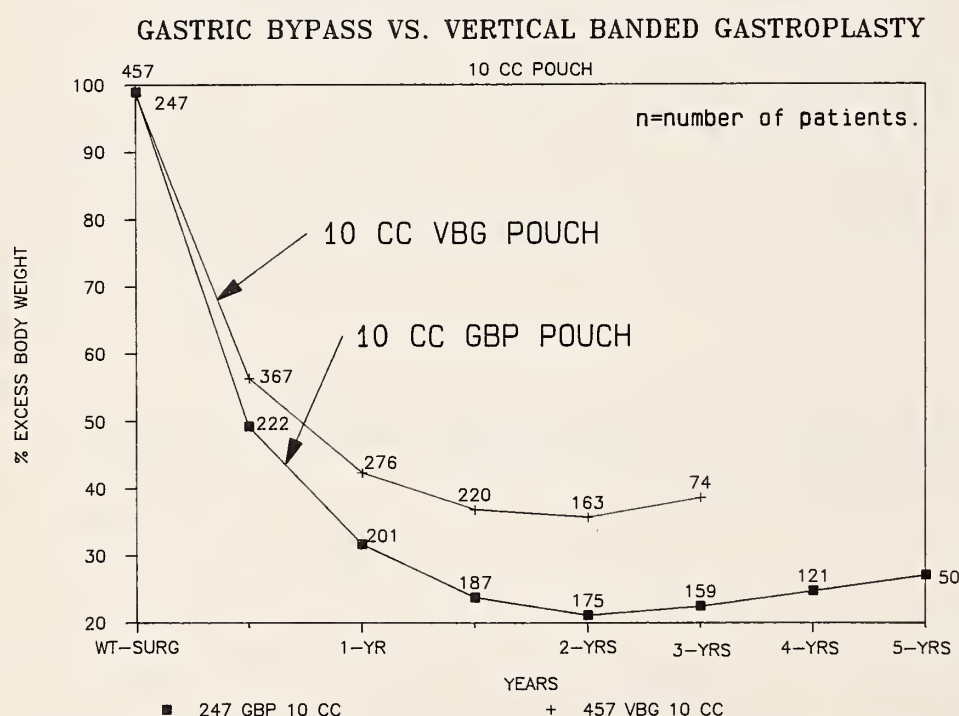


Figure 7: Comparison of weight loss of gastric bypass (GBP) and vertical banded gastroplasty (VBG) patients.

310-pound woman who had psoriasis over most of her body. The psoriasis has cleared from most of her body, possibly reflecting her greatly improved psychologic state following extensive weight loss.

in the obese person's increased risk of premature death has not been determined. Certainly successful weight loss leads to amelioration of risk factors for cardiovascular disease, such as diabetes, hyperten-



Among the children of women who became pregnant soon after bariatric surgery in our practice, we found no evidence of fetal abnormality. Scientists at the Centers for Disease Control analyzed our data as well as Mason's to look for a possible increase in the incidence of birth defects among infants born to women who had lost weight through surgery. The epidemiologists had been alerted by the occurrence of three birth defects among infants born to women who had obesity surgery in one practice. They found no increased risk in the overall data and concluded that the cluster had been a statistical anomaly. (Personal communication.)

Most women do not become pregnant until at least 6 months postoperatively, following the period of maximum weight loss and reversal of hormonal irregularities. The data indicate that at that time pregnancy does not pose a threat to either the mother or the fetus.

The interpretation of massive obesity as psychoneurosis or maladaptive behavior predicts that weight loss will cause conversion of the inner conflict to some other maladaptive behavior. Follow up of persons who have had bariatric surgery reveals that this is not the case.<sup>15</sup> In fact, most patients react to the weight loss with a very normal feeling of pleasure.

Together with psychologist Greg Jarvie, Ph.D. of Georgia College, we have explored the psychology of morbidly obese patients pre- and postoperatively. We find that after surgery, patients are less depressed, less anxious, and have a better self-image. However, they continue to see themselves as morbidly obese for a long time, even after they approach normal weight. Our positive findings agree with those of Stunkard, et al<sup>16</sup> who reported striking improvement in vocational and psychosocial functioning and marital relations after surgical weight loss. They added that the emotional state of patients during weight loss following surgery is far superior to that during attempts at weight reduction by other methods.

Even with diligent follow up, we cannot take complete care of patients on whom we have done sur-

## 509 GASTRIC BYPASS PATIENTS COMPARED TO 93 OBESITY OPERATIONS CONVERTED TO GBP.

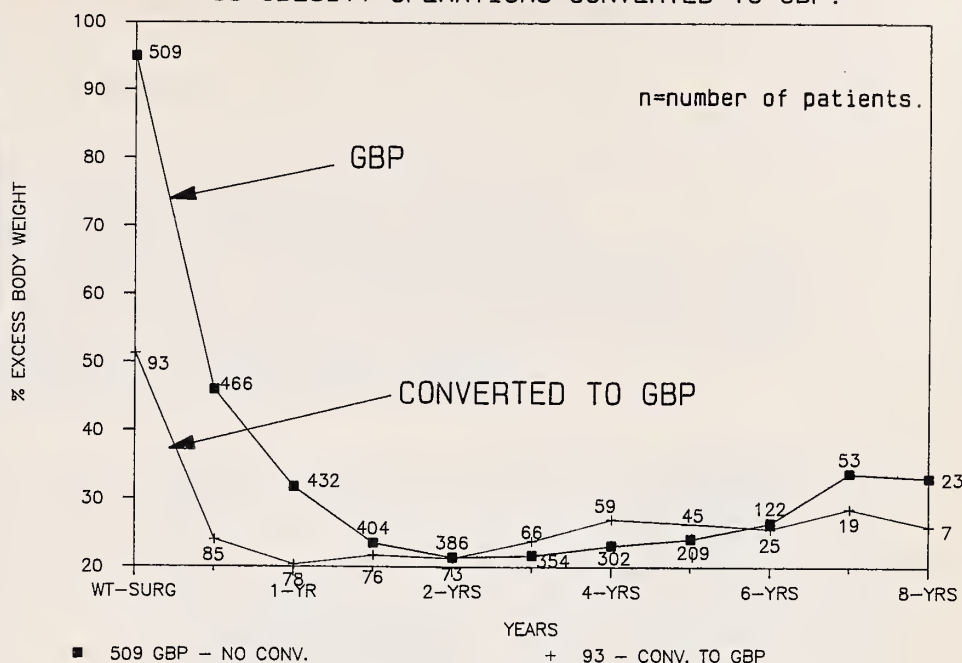


Figure 8: Other bariatric procedures converted to gastric bypass (GBP).

gery for morbid obesity. These patients' own physicians need to become acquainted with the patients' procedures, their probable postoperative weight loss course, and the potential complications of the surgery. We are happy to cooperate with any physicians who wish to learn more about their patients' weight-loss surgery. The encouragement of a primary care physician is valuable to a patient attempting to regulate his or her eating patterns to get the greatest benefit from the surgery.

The advantage to the primary care physician of knowing about a patient's weight-loss procedure comes when an emergency arises, whether or not the surgery is the causation of the problem. This can be important, since in certain situations it is imperative to act quickly and correctly to care for a patient who has had obesity surgery. At the very least, the physician should know how to get in touch with the surgeon who did the procedure to get the benefit of his experience.

## Summary

Persons who are 20 percent or more over ideal weight have a greatly increased risk of premature death as well as being subject to a range of debilitating diseases. When a person reaches 100 pounds or more above ideal weight, he or she may become a potential candidate for surgery to promote weight loss and maintenance of weight loss, with its accompanying improvement in related medical problems. The earliest successful surgical procedure, jejunioileal bypass, is no longer done because better bariatric surgical procedures have been developed. Gastric bypass is an efficient successful procedure for producing extensive long-term weight loss, but it is difficult to perform and may have a high rate of complications in inexperienced hands. Vertical banded gastroplasty appears to be the safest procedure in the variatric surgeon's repertoire at this time for the management of medical problems related to morbid obesity.

# 457 VERTICAL BANDED GASTROPLASTY PATIENTS COMPARED TO 21 OBESITY OPERATION CONVERTED TO VBG.

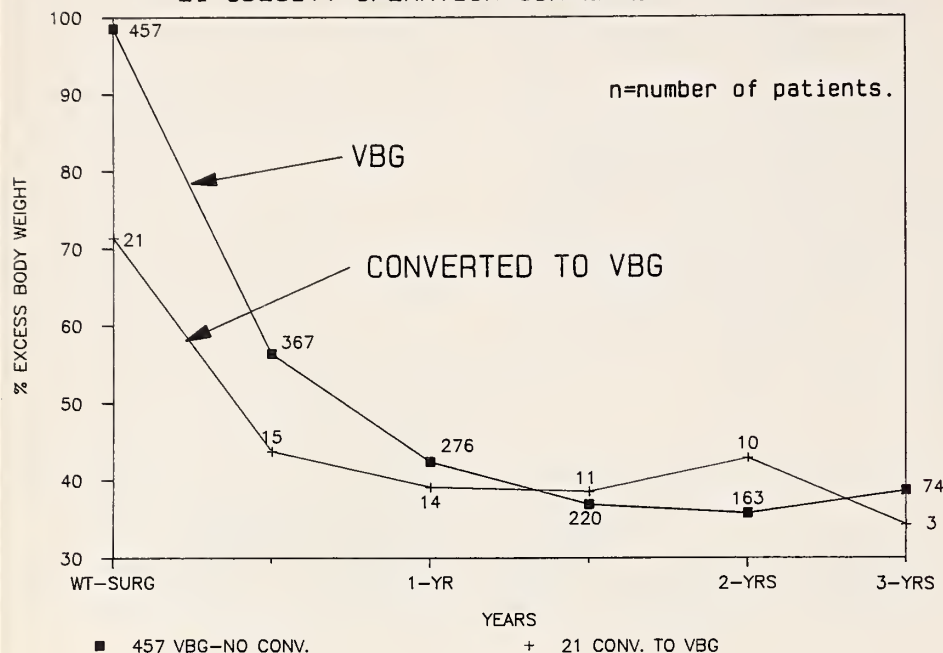


Figure 9: Other bariatric procedures converted to vertical banded gastroplasty (VBG).

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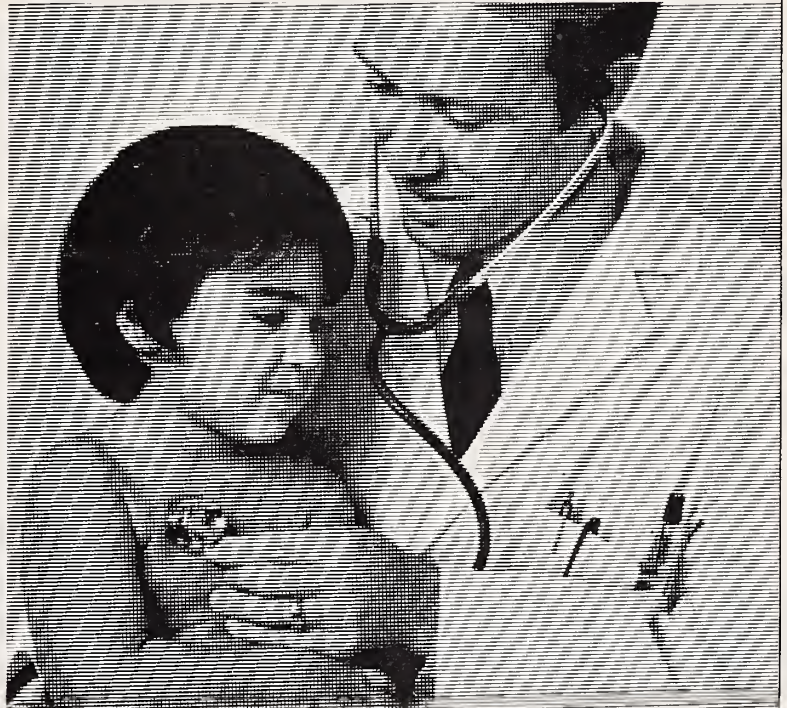
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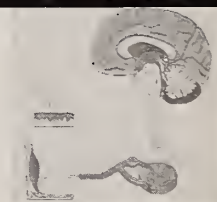
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Willingway: A Fellowship in Alcoholism and Drug Addiction



# Neurosurgical Experience with Nd:YAG Laser

Fremont P. Wirth, M.D., Edward F. Downing, M.D., Cliff L. Cannon, Jr., M.D.,  
Roy P. Baker, M.D.

## Introduction

**S**INCE THE INTRODUCTION of lasers in 1960, these devices have been applied to many areas of medicine.<sup>1,2</sup> The argon laser has been used in ophthalmology, and the carbon dioxide laser has been used extensively by gynecologists and otolaryngologists. The carbon dioxide laser has also been employed in neurosurgery because of its ability to vaporize tissue with precise control. The ability to vaporize tissue and the cutting capabilities of the carbon dioxide laser have been well documented.<sup>3,4</sup> Tissue welding has also been described with milliwatt versions of these lasers.<sup>5</sup>

Use of the Nd:YAG laser in medicine is a more recent development. It has been established as effective in the pulmonary, gastrointestinal, and urologic surgical fields. Experience with the Nd:YAG laser in neurosurgery, however, is more limited. We have had the opportunity to participate in the initial stages of the evaluation of the Nd:YAG laser in this country through an investigational use protocol from the

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**The capability of the Nd:YAG laser to coagulate tissue beneath the surface offers theoretical advantages in destruction of tumor attachments to the skull base and bone flaps.**

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Food and Drug Administration. This report concerns our experience during the past 3½ years and expands upon that which we have reported previously.<sup>6</sup>

## **Characteristics of the Nd:YAG Laser vs. the Carbon Dioxide Laser**

The Nd:YAG laser has a wavelength in the near infrared spectrum, 1.06 microns. The energy of the laser beam is therefore prefer-

entially absorbed by pigmented structures, unlike the carbon dioxide laser. Vascular lesions and other pigmented tissues, such as tumors, absorb the Nd:YAG laser energy which is converted to heat in these tissues producing coagulation necrosis.<sup>7-12</sup> In this manner, the Nd:YAG laser acts as a volume coagulator. Whereas the carbon dioxide laser energy is absorbed on the surface of the tissue, vaporizing the areas it contacts, the Nd:YAG laser penetrates the tissue to a depth of 6 to 7 millimeters causing coagulation of the tissue. The value of this form of laser energy has been emphasized by Beck in Germany and by Takeuchi in Japan.<sup>13-15</sup>

The availability of a fiberoptic (flexible) delivery system for the Nd:YAG laser is another fundamental difference and potential advantage over the carbon dioxide laser, which at present requires a rigid delivery arm.<sup>11</sup> Moreover, the beam of the Nd:YAG laser is not absorbed by colorless fluid and can therefore be transmitted through cerebrospinal fluid. The ability to coagulate veins up to 3 millimeters in diam-

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eter under water is a definite advantage when compared to the carbon dioxide laser.<sup>16</sup>

### Materials and Methods

The Medilas YAG laser (MBB-AT, Munich, Germany) was used under investigational Food and Drug Administration permits at St. Joseph's Hospital and Memorial Medical Center in Savannah, Georgia, through the spring of 1986. These studies were supervised at each hospital by the respective investigational use committee. The Nd:YAG laser was approved for hemostasis in neurosurgery in 1986.

A total of 46 cases were operated on during this 3½-year period. These are detailed in Tables 1 and 2. Standard operating exposures

**TABLE 1 — Operations Using Nd:YAG Laser 1983-86, Savannah**

<b>Meningioma</b>	
Basal	10
Convexity	9
Cerebellopontine	2
Subtotal	21
<b>Glioma</b>	
Glioblastoma (Recurrent)	3
Ependymoma	1
(Recurrent)	2
Oligodendroglioma (Recurrent)	2
Subtotal	8
<b>Sella Tumor</b>	
Pituitary Adenoma	3
Cyst	1
Craniopharyngioma (Recurrent)	1
Subtotal	5
<b>Acoustic Neuroma</b>	1
<b>Hemangioblastoma</b>	2
<b>Arteriovenous Malformation</b>	2
<b>Metastasis</b>	2
Subtotal	7
<b>TOTAL</b>	<b>41</b>

were used together with the operating microscope where indicated and other adjunctive measures such as corticosteroids. The ultrasonic aspirator (CUSA, Cavitron Surgical Systems, Inc., Stamford, CT) was used in many instances and was of great benefit in speeding removal of the devascularized tumor. Details of many of these cases have been reported previously.<sup>6</sup>

**TABLE II — Operations on Spine Tumors Using Nd:YAG Laser, 1983-86, Savannah**

<b>Extradural</b>	
Metastasis	2
Chondrosarcoma	1
Chordoma	1
Subtotal	4
<b>Intradural</b>	
Neurilemmoma	1
<b>TOTAL</b>	<b>5</b>

The laser was used in the continuous mode. Power bursts of from 2-5 seconds were applied through various manually controlled focusing hand pieces. The bayonet-shaped, air cooled hand piece proved to be the most optimal of several designs tried. Power settings of 10 to 20 watts were adequate for most procedures and, indeed, settings of 5 watts were occasionally adequate. Power settings of up to 60 watts were used for tumor destruction in free bone flaps (the Medilas laser, MBB-AT, Munich, Germany, delivers power bursts of up to 5 seconds duration and of up to 100 watts).

Protective eye wear was worn at all times by all operating room personnel, and the window panels of the operating room doors were covered with protective film or opaque cloth. A nurse was designated to assist with operation of the laser at all times.

### Results

Three patients died in the perioperative period. Two of these were over 70 years of age. One with a frontal lobe tumor died of a cardiac arrhythmia 3 days postoperatively, and a second patient with known severe cardiac disease died 3 weeks after an otherwise uneventful recovery from removal of a large olfactory groove meningioma. The third, a 27-year-old patient with a recurrent foramen magnum tumor, died 4 days postoperatively following her seventh craniotomy for multiple meningiomas associated with Von Recklinghausen's disease. None of these deaths could be attributed to the use of the laser.

Transient cranial nerve palsies were observed in all four middle fossa basal meningiomas following

laser radiation of their attachments to the skull base. Two patients had transient worsening of preoperative deficits which subsequently improved, and three patients had delayed development of facial weakness ipsilateral to tumor removal. These changes, which appeared on the 4th and 7th postoperative days, cleared completely by the 21st day.

Nd:YAG laser radiation was particularly effective in meningiomas in decreasing blood loss. These observations have been made by others as well.<sup>4, 13-15, 17, 18</sup> Transfusion in this series was rarely necessary despite the removal of several highly vascular meningiomas of greater than 100 ccs volume, where blood loss requiring replacement might otherwise have been expected. This hemostatic effect was also noted in the two hemangioblastomas surgically removed. For the gliomas encountered, hemostasis provided by the laser was of less benefit and in general hemostasis from these tumors is less of a problem. The ability of the Nd:YAG laser to coagulate the dura of the sella floor prior to transphenoidal surgery was also useful but not essential to this surgical approach. The laser was not used on the intrasellar contents.

In the spine, as intracranially, the Nd:YAG laser was of unique benefit in the control of hemorrhage from vascular lesions such as metastases, where hemostasis is frequently a problem. Despite two highly vascular tumors, one an undifferentiated carcinoma and another a thyroid carcinoma, blood transfusion was avoided, and bleeding from bony metastases was well controlled with the laser.

**The Nd:YAG laser causes heating of a much greater volume of tissue than the carbon dioxide laser.**

The capability of the Nd:YAG laser to coagulate tissue beneath the surface offers theoretical advantages in destruction of tumor at-



tachments to the skull base and bone flaps. Of 10 basal meningiomas where the laser was used to irradiate tumor attachments, recurrences are known to have occurred in two cases 14 months postoperatively. Follow up of five of the remaining eight cases after 2 years has shown no sign of recurrence. Destruction of tumor attachments to free bone flaps is possible with high power settings without concern for injury of adjacent structures. This does appear to be effective in destroying residual tumor. No recurrences have been seen in any of these five cases.

Follow-up in this series of 46 patients has averaged just under 23 months, range 1 to 38 months. No unanticipated side effects of the Nd:YAG laser were encountered. Because of the penetrating ability of this laser, great caution must be exercised when it is used adjacent to vital structures. It causes heating of a much greater volume of tissue than the carbon dioxide laser, and we have documented electrophysiologic changes in tissue adjacent to tumor during irradiation.<sup>14</sup> This limits the use of the Nd:YAG laser in critical areas, such as the spinal cord, and adjacent to critical structures of the base of the brain, such as the optic and selected other cranial nerves.

It is essential that operating surgeons be capable of appreciating the three dimensional effects of the laser beneath the visible surface of the operating field if they are to use this device with safety. Other risks, such as tissue explosion from the Nd:YAG laser, must also be considered and have been reported by others.<sup>20</sup> We believe these can be avoided by careful use of the laser with low wattage settings and more abbreviated power bursts of 5 seconds or less. We have not experienced these unfortunate changes in our patients.

### Conclusions

The Nd:YAG laser provides the neurosurgeon with an additional tool for control of hemostasis from

## The ability to deliver the Nd:YAG laser beam under water or cerebrospinal fluid offers the prospect of endoscopic surgical uses which have not as yet been perfected.

vascular tumors. Acting as a volume coagulator, this device not only devascularizes tumors but also shrinks them, making removal easier and relatively bloodless. The availability of fiberoptic delivery systems also simplifies the use of the device relative to other lasers. The penetrating ability of this laser, which provides its unique hemostatic properties, is also cause for caution, and necessitates restriction of the use of this device to surgeons experienced with its properties because of the potential to damage adjacent, normal structures. Future applications of the Nd:YAG laser are many. While this laser is not presently known to be effective in prolonging survival from malignant brain tumors, the use of this laser, together with appropriate photosensitizing compounds, may allow for selective tumor cell destruction. The ability to deliver the Nd:YAG laser beam under water or cerebrospinal fluid offers the prospect of endoscopic surgical uses which have not as yet been perfected. Milliwatt Nd:YAG lasers may also allow tissue welding and much wider application to vascular problems in the future.<sup>21</sup>

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## Acting as a volume coagulator, this device not only devascularizes tumors but also shrinks them, making removal easier and relatively bloodless.

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# Science and Serendipity: The Morphology of the Conduction System and Surgery for Supraventricular Arrhythmia

Will C. Sealy, M.D.

## Introduction By Serendipity

SOME YEARS AGO when I became interested in cardiac arrhythmia surgery, I soon found that I had to get closely acquainted with the morphology of the cardiac conduction system, if I expected to avoid injuring it or wanted to alter it. During this search, I was impressed that many of the important discoveries were made while the investigators were searching for something else. The word for these happy events is *serendipity*. Since I now have more time for fun things, I looked up the derivation of this odd term, which in Webster's *Ninth New Collegiate Dictionary* is defined as: "the gift of finding valuable and agreeable things not sought for." The word is frequently used as a dignified substitute for the term luck. Horace Walpole, who in 1747 introduced "serendipity" into the language, included something else. His source was the Persian fairy tale of *The Three Princes of Serendip*.<sup>1</sup> Walpole's account is as follows: "As the princes travelled, they were always making discoveries by accident and

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**An interesting historic review of experiments that revealed, often serendipitously, the morphology of the conduction system and how these have influenced surgery for supraventricular arrhythmia.**

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sagacity of things which they were not in quest of." The key word and difference here with Webster is sagacity. Some have suggested that there are individuals who are blessed with this faculty, the good luck of finding unexpected treasures.

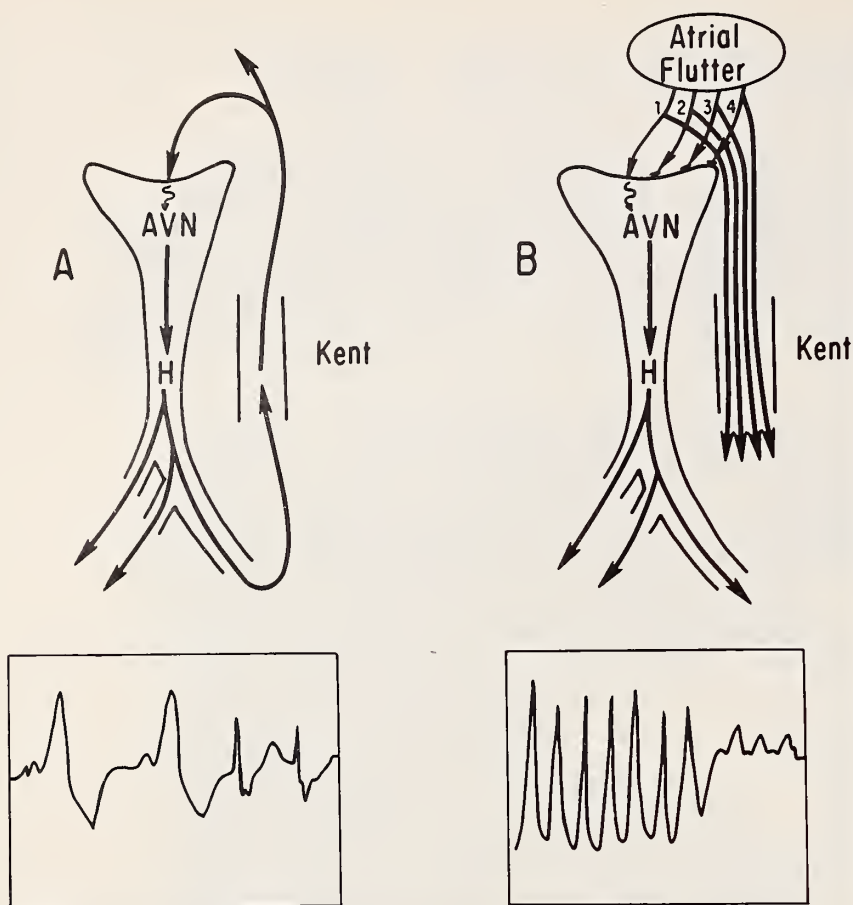
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In writing about arrhythmias, I feel humble, for I am a practical morphologist, not an electrophysiologist, thus my interest in the surgical anatomy of the conduction system. Let's begin by looking back. Carl Wiggers<sup>2</sup> quoted B. G. Niebuhr, who stated quite well what fun it is to check on history: "He who calls the departed ages back again into being enjoys a bliss like that of creating." This is the happy approach to history rather than that usually attributed to Santayana, which poses the threat of dire consequences, if one does not heed history's lesson.

## **An Historic View of the Anatomy of the Conduction System**

In understanding the morphology of the conduction system, two early experiments stand out. They could be called surgical experiments. Both were designed to prove that impulse conduction from atrium to ventricle was neurogenic. The first investigator, Walter H. Gaskell, of the famous Cambridge School of Physiology, was one of many scientists at that time study-



*Figure 1 — Kent bundle causes two types of tachycardia. On the left is shown the pathways involved in the reentry supraventricular tachycardia. It is started by an extra atrial beat. The atrial impulse enters the atrium by the AV node. This changes the QRS to normal and is sometimes called narrow QRS tachycardia. To complete the circus movement, the impulse enters the atrium by a now excitable Kent bundle.*

*On the right, the effect of atrial flutter is diagrammatically shown. Had not a pathway been present, many of the impulses would have been rejected in the AV node. With a Kent bundle that has a short refractory period, the impulses go one-to-one to the ventricle leading to a malignant ventricular arrhythmia.*

ing the autonomic nervous system. He noted in 1883<sup>3</sup> that atrioventricular conduction in the turtle continued after nerve ablation. Conduction occurred through the myocardium, which in this specie is continuous from the atrium to the ventricle. In other experiments, he interrupted in stages the connection between the proximal and distal atrium. When stimuli were applied proximal to the cut and the division progressively increased, the response in the distal atrium

changed from a one-to-one to a two-to-one, and eventually to a three-to-one. Could this be a model for an operation to inhibit AV nodal conduction in patients who have what is called enhanced AV nodal conduction rather than producing heart block as is now done?

The next beneficiary of serendipity, Wilhelm His, Jr., was reared in an environment conducive to study and research. His father is numbered among the great embryologists of all time. The younger His

was also interested in the autonomic innervation of the heart. Naturally, of course, he did his first studies in 1892 on the chick embryo. He was surprised to find that atrioventricular (AV) conduction developed before the innervation of the heart occurred.<sup>4,5</sup> Wondering that if nerves did not, what did, he then discovered a small bundle of myocardial tissue that connected the atrium to the ventricle. In a search for further proof that this myocardial bundle was indeed the atrioventricular conduction system, he made 21 attempts to divide it in the rabbit. He was successful in two, a feat that I have found hard to do by incision.

Albert Francis Stanley Kent, a Doctor of Science, was a contemporary of Wilhelm His, Jr. He was really the first to prove that AV conduction in the mammal was myogenic.<sup>6,7</sup> He must have tried to make his mammal model fit the turtle model described by Gaskell, for he described more than one normal myocardial AV connection. Maybe Kent belonged to that error-prone group that is the opposite of those blessed with serendipity. Kent's place in history is now permanent as an eponym. Kent bundle is synonymous with anomalous atrioventricular pathway. In recent years, both interesting and heated discussions have occurred concerning the fairness of establishing his figurative cenotaph, which an eponym really is, on the basis of an error.

Another morphologist and pathologist, Suna Tawara, of Japan, began his Western studies early in this century with the famous German pathologist, Aschoff. Tawara was given the task of examining the hearts of patients who died from diphtheria. In this study, he confirmed that a His bundle was in fact present, but was only a part of the atrioventricular conduction system. This began as a club-shaped structure in the atrial septum.<sup>8,9</sup> It then extended, by well demarcated fibers, through the posterior aspect of the central fibrous body to the endocardium of both ventricles. He and his mentor, Aschoff, did not become so taken with diphtherial heart disease that they didn't appreciate the significance of the AV node. This fits Walpole's definition



of serendipity, luck plus sagacity.

One of my favorite studies was that of Arthur Keith, who along with Martin Flack, a neighbor and medical student, found the SA node.<sup>10</sup> Although Keith had extensive anatomic experience with hearts, he had trouble confirming that Tawara and Aschoff had found a separate structure that we now know as the AV node. In a continuation of experiments to confirm Tawara's work, he and Flack looked for the AV node in a variety of animals and found, by serendipity, the SA node. The following is an excerpt from Keith's account of this discovery:

"In the long vacation of 1906, Flack and I turned my study at Bredgar into a laboratory — microtome, oven, microscopes; we had a vast store of human hearts and were trapping moles, rats, mice, and hedgehogs with the intention of verifying and extending Tawara's discoveries of their hearts. I remember well one very hot day, late in the summer of 1906, my wife and I going out on our bicycles leaving Martin running serial sections of a mole's heart. On returning, he bade me look through a microscope at a strange structure he had found at the junction of the superior cava with the right auricle. The structure was muscular but quite different from the musculature round about. I remember the body I had seen in the MacKenzie hearts; we set to work and found it at the same site in all the mammalian hearts at our disposal. In structure it resembled the node of Tawara; hence, we inferred it to be the site at which the cardiac rhythm was normally initiated."<sup>11</sup>

Unfortunately, there are problems with the surgical morphology that may require the assistance of serendipity to solve. In the atrial myocardium outside the nodes of Keith and Flack and Tawara, exciting events occur in what appears under the microscope to be ordinary working myocardium. For example, the preferential pathways of conduction from the SA node to the AV node assume this role only by virtue of their mass. Pacemakers capable of controlling the heart

beat, when the SA node does not function, are in working myocardium in the region of the coronary sinus. There are two separate pathways in the AV node and its approaches, only identifiable by electrophysiologic means, but which can be the routes of reentry.

### More Modern Surgical Approaches

In emphasizing the anatomy of the conduction system, I have failed to mention the mechanism of supraventricular arrhythmias that the surgeon can help by an operation. There are two clinical types, with a third, atrial fibrillation and flutter, that is hard to define. Reentry atrial tachycardia requires two pathways connected at each end, but with different electrophysiologic characteristics (Figure 1). The classic example is that associated with WPW. An extra atrial beat usually finds the Kent bundle refractory, while the AV node and bundle are excitable. Passage through the AV node is slow, and when the impulse arrives at the ventricular end of the Kent bundle, it is now excitable. Reentry in the atrium occurs, causing a circus movement. Reentry tachycardias can be induced and reverted by programmed stimulation. The latter is a part of the preoperative electrophysiologic study.

Automatic or focal atrial tachycardia occurs when cells other than those of the SA node fire at a faster rate than the node and take over control of the heart's rhythm. When the tachycardia starts, the rate increases for the first few beats. When the tachycardia stops, there is a pause as a new pacemaker takes over. Programmed stimulation will neither induce nor revert the tachycardia. It is thought that automatic tachycardia occurs when there is either a severe metabolic problem or myocarditis. In automatic atrial tachycardia, the surgeon has shown that many patients have a single site of origin that can be excised, excluded, or ablated. A few months ago, I found more than 50 reported examples distributed about both atria.

Atrial fibrillation-flutter is a common arrhythmia problem that does not fit any of the above. Surgical treatment is palliative and drastic, requiring the production of heart block. The indications for operation are an uncontrollable fast irregular ventricular response causing low cardiac output. For the uncontrollable situation to occur, the AV node has to have enhanced conduction characteristics. In years past, other atrial tachycardias were treated this way. I have had experience with more than 50 open ablations through the open heart, mostly because of fibrillation-flutter, almost all by destruction of the AV node with cryothermia.<sup>12</sup> Now catheter surgeons report hundreds of patients who have ablation with a catheter electrode connected to a defibrillator, achieving 90% success.

Let me give a personal example of failure to take advantage of luck, and thus elevating it to the level of serendipity. A patient with uncontrollable AV nodal reentry tachycardia needed His bundle interruption. Reentry in AV nodal tachycardia is over two physiologically distinct, but not recognizable morphologic pathways in the AV node and its approaches. Efforts through the open right atrium to interrupt conduction by cryothermia failed. I was called to the operating room to produce heart block by an incision I had developed in the laboratory. As the first step in dividing the AV node from the His bundle, part of the atrial septum was divided. The AV nodal reentry was interrupted, and normal AV conduction continued. Another step that was important but not appreciated had already been done. The superior approaches to the node and the right atrial component of the atrial septum had been extensively damaged by the cryothermia. This patient's tachycardia was cured, as confirmed by an electrophysiologic study 4 years later.<sup>13</sup> If ever there was an opportunity to upgrade luck to serendipity, this was it. Some 8 years later, two sagacious doctors in Australia applied the same essentials to a large number of patients and proved it to be a useful operation.<sup>14</sup>

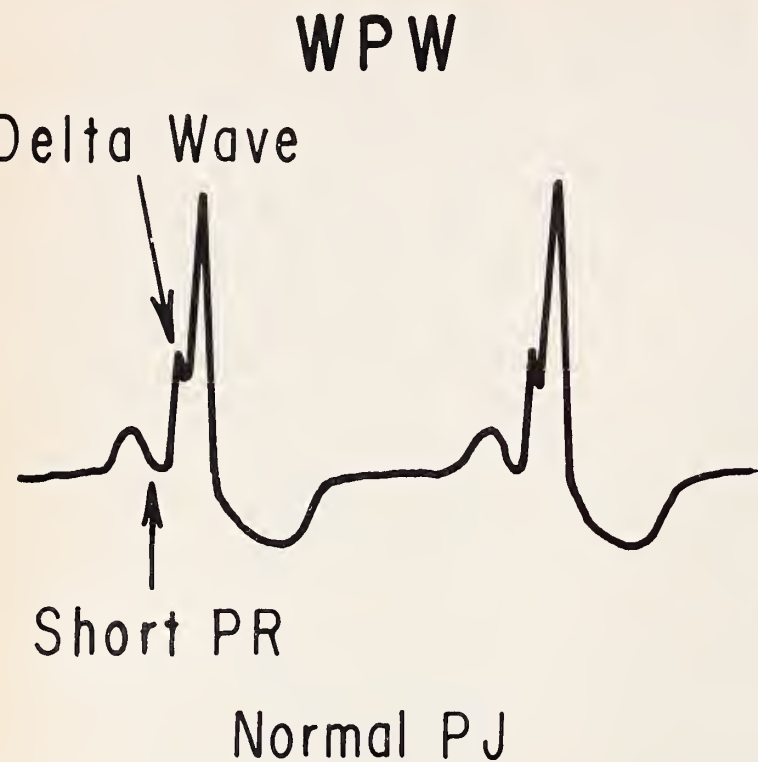


Figure 2 — This tracing represents the changes that occur in the ECG with an accessory pathway of conduction or Kent bundle. Since the atrial impulse, shown by the P-wave, avoids the AV node and bundle, it arrives at the ventricle early. This is described as a short PR interval. When the impulse reaches the ventricle, it causes a slurring of the QRS wave. This notch on the upstroke is called a Delta wave. The QRS is wider than normal. The time lapse from P to J is normal. This is preexcitation, which means ventricular excitation before the impulse arrives by the His bundle.

Dr. Paul White, of Boston, and his colleagues reported in 1928 on a group of young people with short PR intervals and wide QRS complexes; who had episodes of tachycardia (Figure 2).<sup>15</sup> They were at a loss to explain exactly why this peculiar syndrome, now named for them, occurred. Nearly 10 years later, Doctors Francis Wood and Charles Wolferth of Philadelphia had a patient with the syndrome who died during an episode of arrhythmia.<sup>16</sup> They analyzed this problem very carefully. In looking for an explanation, they remembered Albert Francis Stanley Kent's papers, which erroneously described more than one normal AV myocardial connection. They postulated that two pathways, the Kent bundle and His bundle, would explain the mechanism for a reentry tachycardia, as well as the short PR interval

and the Delta wave. They did serial microscopic sections on the right free wall of the heart, the place that Kent described a second connection in man. Here, they found the bundle.<sup>17</sup> Although lucky, unquestionably, they were sagacious. Preexcitation, as well as reentry could only be explained by two atrioventricular pathways.

My experience with WPW began 20 years ago when a fisherman from the North Carolina coast was admitted to Duke Hospital with a refractory supraventricular tachycardia due to an accessory pathway.<sup>18</sup> Because of previous studies of activation sequences of the myocardial surface done in the operating room, my colleagues and I were ready to locate the accessory pathway of AV conduction, the Kent bundle. It was found, and interrupted, on the right free wall just where Wood found the first one and

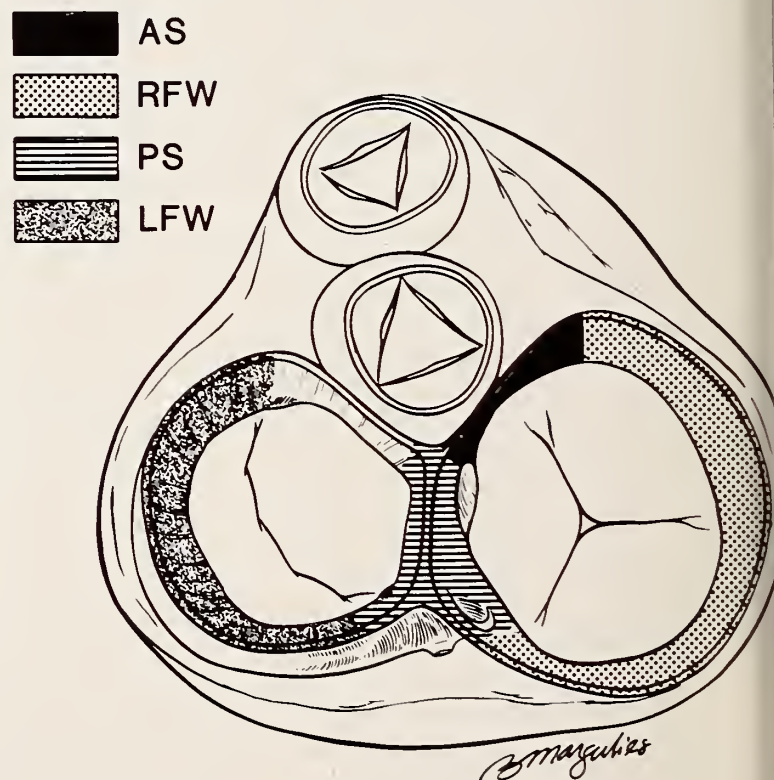


Figure 3 — This shows a horizontal section through the heart just above the two AV valves, which depicts the various locations of Kent bundle. AS is anterior septal; the posterior septal (PS) includes the membranous ventricular septum shown as the small white ellipse. The left free wall (LFW) extends from the muscular ventricular septum posteriorly to the left fibrous trigone anteriorly. Note there are no pathways where the mitral annulus and aortic annulus abut each other. The right free wall (RFW) begins arbitrarily where right coronary artery enters the sulcus and extends to muscular ventricular septum posteriorly.



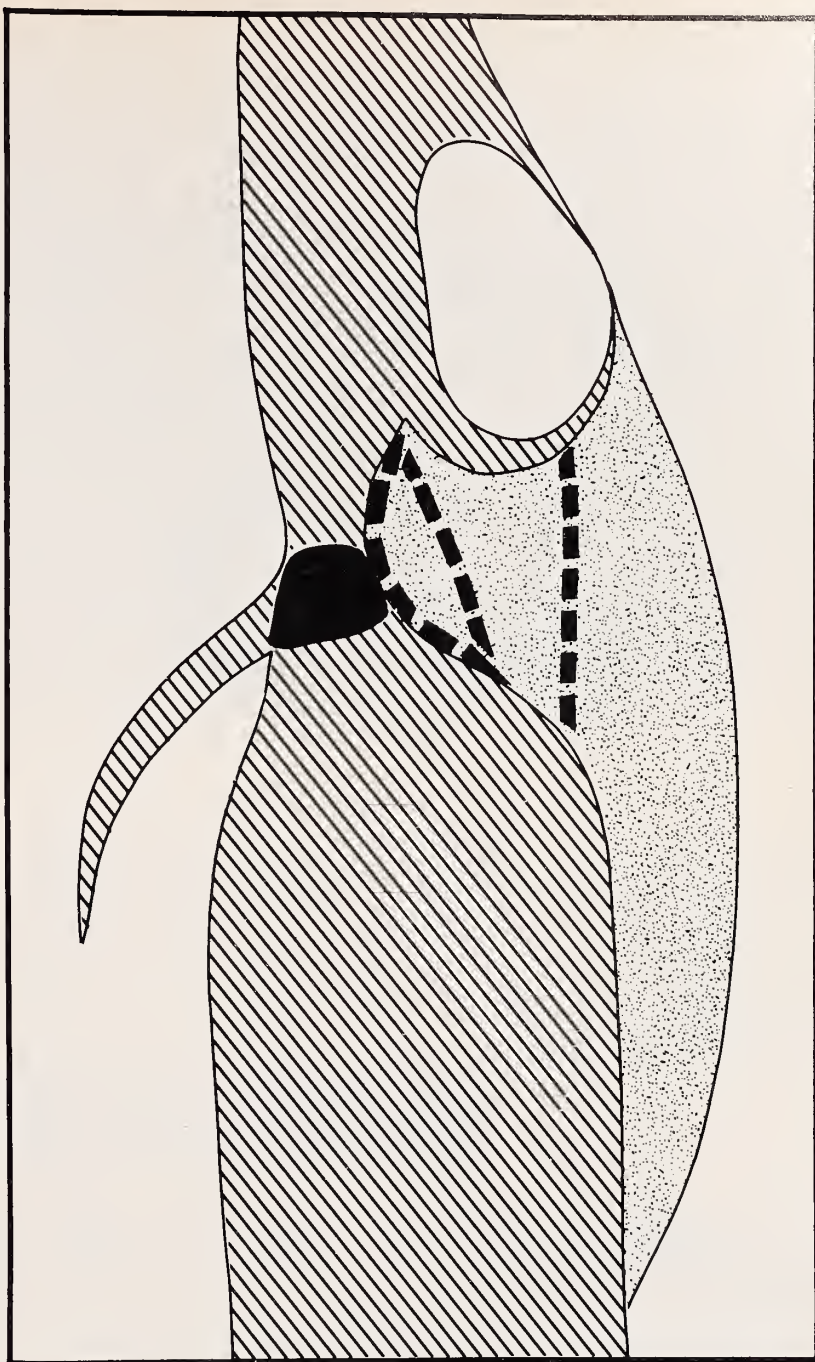
where Kent thought normal pathways existed. My experience with this operation has grown to nearly 400 patients.

Kent bundles are minute and are not grossly visible or palpable as they cross from atrium to ventricle. Their width may be a millimeter or less. There may be more than one pathway, up to three in my experience. They can be anywhere that atrium and ventricle abut each other. I devised a practical classification which is now generally used. Pathways can be in the right free wall, left free wall, anterior septal, or posterior septal areas (Figure 3).

Pathways may have different physiologic properties. Some pathways will only conduct from ventricle to atrium, causing frequent episodes of reentry tachycardia. After AV nodal reentry, this is the second cause of supraventricular reentry tachycardia. The ECG between episodes of tachycardia will be normal. Rarely, a pathway will only conduct antegrade, in which case it will be the unlikely participant in reentry, but can cause a more dreaded problem just as can a pathway with both antegrade and retrograde capacity (Figure 2). If the antegrade function of a pathway has short effective refractory period, that is, it recovers its excitability early, then this pathway may conduct a fast atrial rate, such as atrial fibrillation-flutter, one-to-one to ventricle. This causes what is, in fact, a malignant ventricular arrhythmia. That can degenerate to ventricular fibrillation. In my experience, 25% of patients had to be operated upon because of this problem. The other reason for operation was frequent episodes of refractory reentry tachycardia. Young people, in particular, who need constant medication should have the operation.

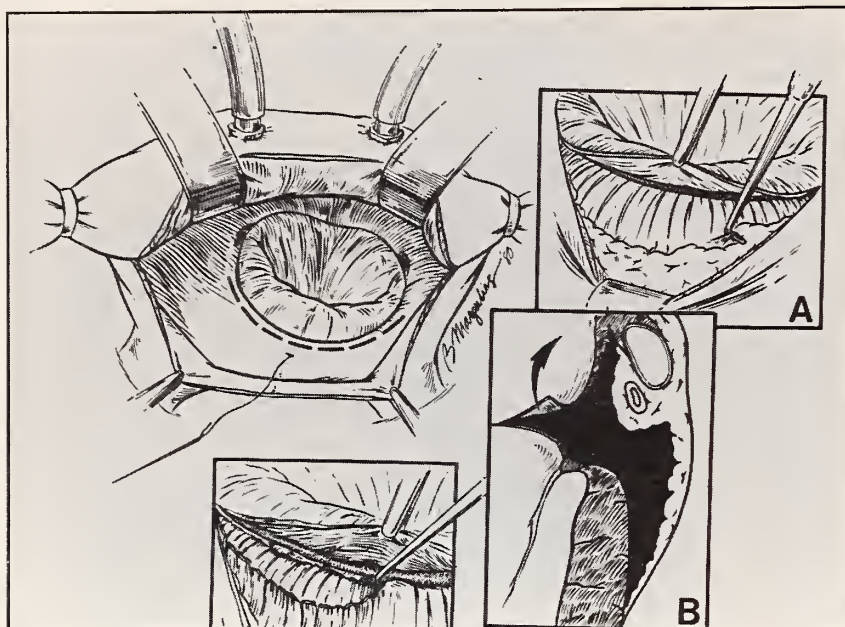
Before operating, however, an extensive preoperative electrophysiologic study is needed to find the pathway, to make sure it causes the tachycardia, and to determine if it has a lethal potential.<sup>19</sup>

**O**perations for WPW are designed to interrupt the accessory pathway, which is one arm of the reentry circuit. To find it, surface maps of the activation sequences of the ventricles are made



*Figure 4 — This shows a vertical section of the left free wall made through atrium, coronary sulcus, and ventricle. The mitral valve is shown attached to the annulus fibrosus to the left. The dotted line to the right shows Kent bundle arising from the atrial muscle that surrounds the coronary sinus. The latter is located superiorly and to the right. This pathway and middle one, arising from the atrium courses through the sulcus fat to the ventricle. The third one hugs the annulus of the mitral valve on its way to the ventricle.*





*Figure 5 — This depicts the operation for a left free wall pathway. The open left atrium is shown above and to the left. A suture is shown piercing the atrium at the pathway's crossing point. The dotted line shows the intended atrial endocardial incision on A. The sulcus fat is separated from the summit of ventricle and mitral annulus. In the lower left, the superficial ventricular fibers are teased away from the annulus. In B, the extent of the dissection is shown. These maneuvers divide all possible pathway crossings.*

during atrial pacing, with an electrode placed close to the atrial side of the pathway. The crossing point to the ventricle causes the earliest area of the ventricular activation. To confirm the site of the atrial end of the pathway, ventricular pacing can be done and activation times of the atrium at the coronary sulcus measured. A still better way is to induce the reentry tachycardia by programmed stimulation and make the same measurement, for the impulse usually travels down the His bundle and returns to the atria by the Kent bundle.

The operation for a left free wall pathway illustrates a typical procedure done with cardiopulmonary bypass and cardioplegia.<sup>20</sup> After localization of the pathway by maps, the surgeon has to be aware of the routes they take from atrium to ventricle. Figure 4 shows the left free wall pathway routes in this area of the heart. The left atrium is opened

just as for mitral valve operations. An incision is then made in the left atrial endocardium just above the annulus of the mitral valve; second, the coronary sulcus fat is separated from the annulus and ventricular summit; and third the superficial ventricular fibers are divided where they insert into the annulus (Figure 5).

**T**he pathways in the anterior and posterior septal areas<sup>21, 22</sup> are the most challenging of all to the surgeon. This is because of the large number of possible crossing points from atrium to ventricle, as well as the proximity of some of the pathways to the normal conduction system. The AV node is located within the easily identifiable atrial septum, not the right atrium. After the AV bundle emerges from the septum, it penetrates the membranous ventricular septum. Thus, if the surgeon is very careful to identify the

atrial septum and to follow it to its insertion into the central fibrous body, the operator will always know where the AV node is located. Actually, there is no reason for the surgeon to damage the AV node either in operation on the anterior septal or posterior septal locations. The operator must clearly identify the atrial septum and membranous ventricular septum's extension into the right atrium. In the anterior septal area, the AV node and the His bundle are enclosed within the membranous ventricular septum. Pathways coursing adjacent anterior aspect of the membranous septum can be safely divided. Space does not permit further detailed description of operations and the surgical anatomy associated with the Kent bundles in this or other locations.<sup>23</sup>

After division of the pathway, success is shown by absence of preexcitation. To confirm this, atrial and then ventricular pacing are done at increasing rates until the Wenckebach periodicity occurs, showing that AV conduction is now only by the AV Node and His bundle.

### Summary By Serendipity

So by a serendipitous event, the division of an accessory pathway in a fisherman with a fast pulse, set in motion a whole series of rewarding anatomic studies that were applied to patients with a bizarre and unusual cause of supraventricular tachycardia — a Kent bundle, or more properly, an accessory pathway. Arrhythmia surgery has now been expanded to include other kinds of supraventricular arrhythmias. These are automatic and AV nodal reentry. Even atrial fibrillation and flutter are amendable to palliation by a drastic surgical operation now performed with a catheter.

Szent-Gyorgyi's remark offers a fitting conclusion, then, to this morphologic discussion: "There is no real difference between structure and function. They are two sides of the same coin. If structure does not tell us anything about function, it means that we have not looked at it correctly."<sup>24</sup>



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# Successful Implementation of Maximum Surgical Blood Order Schedule

Tracy A. Lowery, M.D., Jerrold A. Clark, M.D.

## Introduction

**T**HE MAJORITY OF UNITS of blood transfused in the United States are administered to patients undergoing surgical procedures. A strategy commonly employed by surgeons and anesthesiologists is to request units of blood in excess of anticipated needs to provide an ample margin of safety in the event of unexpected hemorrhage. In practice, however, preoperative ordering is more often guided by habit than clinical need.<sup>1</sup>

Many investigators show that it is possible to realize considerable cost savings by changing the blood ordering practices of physicians without compromising the quality of patient care.<sup>2, 13</sup> This is accomplished by implementation of a Maximum Surgical Blood Order Schedule (MSBOS). A MSBOS is a list of commonly performed elective surgical

## Abstract

**A Maximum Surgical Blood Order Schedule (MSBOS) is a schedule of commonly performed elective surgical procedures listing the maximum number of units of blood to be crossmatched preoperatively. A MSBOS reduces the preoperative crossmatching of blood in surgical cases in which there is less likelihood of blood transfusion. The reduction in crossmatched units of blood saves hospital time and money.**

**This study presents the steps required to institute a MSBOS. Savings in reduced crossmatch charges were calculated.**

**After a review of 1400 operations, a MSBOS listing 35 operative procedures was established at the Medical Center of Central Georgia. Staff compliance was greater than 99%, crossmatch to transfusion ratio was reduced from 5:1 to 2:1, and our annual savings was greater than \$110,000 in reduced crossmatch charges.**

This paper was presented at the 1988 annual meeting of the Georgia Chapter of the American College of Surgeons, and won first place in a competition of papers submitted by surgical residents to the *Journal of the Medical Association of Georgia*. The competition was originally sponsored by Milford B. Hatcher, M.D., Chairman-Professor, Department of Surgery, Mercer University School of Medicine, Macon (JMAC Jan '85, p. 40).

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procedures with a maximum number of units of blood to be crossmatched preoperatively. The goal of a MSBOS is to make preoperative blood orders more closely coincide with the number of units of blood that will actually be transfused to patients during or immediately after surgery. A MSBOS reduces the preoperative crossmatching of blood in surgical cases in which there is less likelihood of blood transfusion. The reduction in crossmatched units of blood saves the hospital time and money. This is reflected in a decreased outdating of blood, reduced blood inventory, decreased reagent use, and better use of technical time. Reduced preoperative crossmatching results in savings for patients.

## Materials and Methods

An audit of 1400 consecutive in-

patient operations over a 3-month period was performed at our 561-bed regional referral hospital to establish a MSBOS. The audit evaluated the number of patients undergoing each surgical procedure, the number of preoperative crossmatches ordered, and the to-

thesia and finally the Executive Committee of the medical staff. All committees accepted the concept upon realizing the safety of the MSBOS. Prior to implementation, inservice education was given to blood bank, nursing, and operating room staff.

**TABLE 1 — Maximum Surgical Blood Order Schedule for Patients Undergoing Mastectomy**

Number of Patients	10	Mean Units Transfused Per Patient	.10
Pre-Op Crossmatches Ordered	20	Average Units Ordered Per Patient	2
Total Units Transfused	1	Suggested MSBOS	T&S
Crossmatch-to-Transfusion Ratio	20	Annual Savings with MSBOS	\$1,604.00

tal units of crossmatched blood transfused during or within 24 hours of surgery. These data were evaluated for each surgical procedure to determine the crossmatch to transfusion ratio, mean number of units transfused per patient, and the average number of units crossmatched per patient (Table 1). If the average number of units transfused per patient was less than 0.5, a type and screen was suggested.<sup>3,6</sup> Thirty-five of the most common elective operations were placed on the MSBOS (Table 2).

Reduced crossmatch charges were calculated for each of the 35 selected MSBOS cases using the following formula:

Actual preoperative crossmatches ordered for a selected surgery as determined by the audit (minus) — (number of patients in the audit for that surgery (times) × MSBOS recommended preoperative crossmatches) (times) × crossmatch charge.

The dollar figure for each of the 35 MSBOS cases was calculated by taking the 3-month audit result times four (Table 1). The total of the reduced crossmatch charges was the sum of the projected annual figure for each of the 35 surgeries on the MSBOS. This total figure was in excess of \$110,000.

The MSBOS was presented to the Departments of Surgery and Anes-

thesia and finally the Executive Committee of the medical staff. All committees accepted the concept upon realizing the safety of the MSBOS. Prior to implementation, inservice education was given to blood bank, nursing, and operating room staff.

Implementation of the MSBOS was computer assisted.<sup>7</sup> MSBOS sequential order/entry screens were developed by the Transfusion Director, Blood Bank staff, and Nursing Service. The Data Processing Department of the hospital developed software for placing the screens in the hospital order/entry system.

Using the operative schedule, the blood bank technologist or nurse would insert preoperative surgical blood orders on the day prior to surgery based on MSBOS recommendation. After completion of the blood order, specimens would be drawn immediately on inpatients. Specimens on patients admitted during the day prior to surgery would be drawn before reporting to the floor. Outpatient blood bank specimens would be drawn the day prior to surgery during preoperative outpatient registration. This would allow for early collection of all blood bank specimens so that preoperative laboratory work would be completed early in the day. Positive antibody screens would be worked up on the day shift by the most experienced blood bank technologists rather than late in the evening by less experienced technical personnel.

The preoperative blood bank order, based on the MSBOS, would be automatically printed on the patients' floor and inserted into the chart for the physician's signature.

All patient blood samples were tested for ABO and Rh employing routine techniques and commercially available reagents.<sup>8</sup> All sera were screened for unexpected antibodies with a set of three commercial reagent red cells. The screening cells were tested in an immediate spin saline phase followed by a 10 minute 37° C incubation phase with a commercially prepared modified low ionic strength solution containing albumin. An anti-IgG antihuman globulin phase ensued. All antibody screening tests and grading of agglutination reactions were in accordance with the Technical Manual of the American Association of Blood Banks (AABB).<sup>8</sup> Patients with a known history or currently demonstrable clinically significant alloantibodies would have antigen-negative crossmatch compatible blood available exceeding the MSBOS recommendations if appropriate.

The immediate spin crossmatch was initiated to provide intraoperative blood urgently for patients who exceeded the MSBOS recommendation. The immediate spin crossmatch consists of reacting two

**Many investigators show that it is possible to realize considerable cost savings by changing the blood ordering practices of physicians without compromising the quality of patient care.**

drops of the patient serum with one drop of a 3-4% saline suspension of washed donor red blood cells obtained from segments attached to the unit of blood. The mixture was centrifuged for 15 seconds at 3400 rpm and examined immediately for agglutination or hemolysis.

Three months following the implementation of the MSBOS, an audit of 218 consecutive MSBOS operations was performed to determine compliance.



## Results

A 3-month post-implementation audit of 218 consecutive MSBOS operations revealed physician compliance to be greater than 99%. Only three cases exceeded the MSBOS preoperative crossmatch recommendations. One of the three cases was placement of a hip prosthesis in a patient with a hemoglobin of 9.1. Exceeding the MSBOS recommendation was appropriate. The other two procedures, cardiac angioplasty and aortobifemoral bypass graft were "add on" cases. Blood bank orders were generated by the physicians instead of the MSBOS recommendations.

Four surgical cases experienced intraoperative bleeding that exceeded blood held based on the MSBOS. No complaints were filed regarding availability of intraoperative blood during the four cases or any other operations since the program was implemented.

The crossmatch-to-transfusion ratio ideally should not exceed 2.5:1.<sup>2, 6, 9, 10</sup> The crossmatch-to-transfusion ratio for the 35 selected cases on the MSBOS was reduced from 5:1 to 2:1. Compliance has been assured with our computer assisted MSBOS. Annual savings of greater than \$110,000 in reduced crossmatch charges was realized.

## Discussion

A MSBOS is the most effective method of reducing excessive preoperative crossmatching of blood.<sup>1, 2, 4, 5, 11</sup> Many MSBOS operations require only a type and screen (Table 2). No preoperative crossmatching of blood is performed for these operations. To understand the MSBOS requires a knowledge of the type and screen.

The type and screen (also known as the type and hold) consists of an ABO-Rh typing performed by conventional methods and a screen for unexpected antibodies. The type and screen is 99.99% effective in preventing the occurrence of incompatible transfusions.<sup>6, 12</sup> If an antibody is detected during the screen, it is identified and an appropriate number of units of blood negative for the corresponding antigen are crossmatched for that patient. The surgeon is notified of the presence of an unexpected an-

**TABLE 2 — Maximum Blood Order Schedule for Common Elective Operations**

1. Abdomino-Perineal Resection (AP Resection)	2 units
2. Abdominal aortic aneurysm (Y-Graft, Elective)	2 units
3. Amputations-Above knee/Below knee (AKA/BKA)	T&S
4. Angioplasty	T&S
5. Antrectomy/Vagotomy	2 units
6. Anterior/Posterior Repair (AP Repair)	T&S
7. A-V graft/fistula	T&S
8. CABG	3 units
9. Carotid endarterectomy	T&S
10. Cholecystectomy	T&S
11. Colectomy	2 units
12. C-Section	T&S
13. Craniotomy	2 units
14. Cystectomy-Radical	3 units
15. Disc Cervical/Lumbar	T&S
16. Embolectomy/Thrombectomy	T&S
17. Gastrectomy	2 units
18. Gastric Stapling	T&S
19. Gastrostomy	T&S
20. Grafts-peripheral arterial (fem/pop, fem/fem, ax/fem, profundaplasty)	T&S
21. Hysterectomy (TVH/TAH)	T&S
22. Knee Arthroplasty	T&S
23. Mammoplasty	T&S
24. Mastectomy	T&S
25. Mediastinoscopy	T&S
26. Nephrectomy	2 units
27. Prostatectomy	2 units
28. Radical Neck Dissection	T&S
29. Thoracotomy	2 units
30. Thyroidectomy/Parathyroidectomy	T&S
31. Total Hip replacement	2 units
32. Total Knee replacement	T&S
33. Vagotomy/Pyloroplasty	T&S
34. Cardiac Valve Replacement	4 units
35. V-P Shunt	T&S

tibody. If no antibody is detected, the elective surgery proceeds without preoperative crossmatching of blood according to MSBOS recommendations. In the unlikely event that the patient needs blood intraoperatively, an immediate spin crossmatch is performed and blood released to the operating room. The immediate spin crossmatch consists of centrifuging a mixture of donor cells, patient serum, and saline. This procedure provides for an ABO compatibility check prior to releasing blood. The immediate spin crossmatch takes only 5 minutes to perform and thus provides a mechanism for rapid availability of blood products if unexpected bleeding occurs during elective surgical cases.

**I**mplementation of a MSBOS requires cooperation between blood bank and surgical staff. Despite optimal conditions for implementing a MSBOS, physician compliance may still be poor. A surgeon may forget to order according to the

schedule and fall into old ordering patterns. A physician's personal routine order sets for elective surgical cases must be changed to correspond with MSBOS recommendations. Some physicians may distrust the schedule because they lack a clear understanding of the program or lack confidence in the blood bank. Teaching institutions may encounter continuing medical education problems with orientation of new surgical house staff. Incorporation of the MSBOS into the hospital computer order/entry system ensures compliance.

The development of a MSBOS within a hospital is apt to gain physicians' acceptance if it is based, at least in part, on the local hospitals' blood transfusion experience. Some blood order schedules are based on the experience of small individual hospitals or pooled data of up to 300 hospitals.<sup>1, 9, 10</sup> These reports are relatively consistent in their recommendations regarding preoperative blood bank orders. Surgeons



and anesthesiologists, however, are more likely to accept local data than collated data from regional studies.

Reduction in preoperative cross-matches for the 35 selected MSBOS surgeries results in an annual decrease of crossmatch charges exceeding \$110,000. Reimbursement for 50% of our surgical patients is in a DRG-type system. Reduction in preoperative crossmatching for this patient population results in savings to the hospital of technical time, reagents, and expendables.<sup>13</sup> The remaining patients glean direct benefit of approximately \$55,000 representing the balance of the annual reduced crossmatch charges of \$110,000. Our crossmatch to transfusion ratio is reduced from 5:1 to 2:1 for the 35 most common elective surgical procedures performed at our institution. Reduction in preoperative crossmatching allows for maximum availability of blood inventory. Blood outdating is also reduced, since fewer crossmatched units of blood are placed on reserve status and, therefore, unavailable for transfusion to other patients.

A Maximum Surgical Blood Order Schedule can be set up in a hospital of any size. If the steps we present are followed, the physician staff will not only have a more efficient blood bank at their disposal but also one that is cost effective for their patients.

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**In practice,  
preoperative ordering  
of blood is more often  
guided by habit than  
clinical need.**

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## Revisiting Georgia's Medical Malpractice Arbitration Statute

Robert N. Berg, Atlanta

**D**URING ITS 1988 legislative session, the Georgia General Assembly enacted the Georgia Arbitration Code,<sup>1</sup> in order generally to revamp the application and structure of commercial arbitration in Georgia. The new Arbitration Code did not significantly alter certain aspects of Georgia's existing arbitration law, however, including specifically the arbitration of medical malpractice claims. At the same time, adoption of the new Arbitration Code might be viewed as a reminder to physicians and other health care practitioners that Georgia already has in place an alternative dispute mechanism for resolving medical malpractice claims.

***“The arbitration of medical malpractice claims, as an alternative to litigation, has been viewed by many as offering significant benefits.”***

The arbitration of medical malpractice claims, as an alternative to litigation, has been viewed by many as offering significant benefits. For example,

it is argued that arbitration serves to reduce the legal expenses otherwise incurred in connection with medical malpractice litigation. Similarly, the arbitration process may result in more expeditious decision-making than that seen in the typical malpractice case. Additionally, many arbitration supporters contend that the arbitration mechanism may serve to reduce the risk of an unreasonable result (i.e., a “runaway jury verdict”).<sup>2</sup> Georgia's medical malpractice arbitration statute, enacted in 1978 (but still not widely used), is the subject of this month's Legal Page.

### Authorizing the Arbitration of Medical Malpractice Claims

In the typical commercial setting, the parties to a contract may agree, in that contract, to arbitrate all or certain specific future disputes. In contrast, the arbitration of medical malpractice claims under Georgia law *cannot* be authorized at the time the physician and patient enter into the “agreement” for the provision of health care services. Rather, a medical malpractice claim may be arbitrated only by an agreement, entered into in writing

subsequent to the alleged malpractice and “after a dispute or controversy has occurred.” Moreover, no agreement to arbitrate a medical malpractice claim may be entered into unless the claimant at that time is represented by legal counsel.<sup>3</sup>

Once the parties to the dispute have entered into a written arbitration agreement, they must petition the superior court of the county where either of the parties reside, to obtain an order authorizing arbitration. Within 30 days of the filing of this petition, the court is required to appoint a referee, who serves as a non-voting member of the arbitration panel. By law, the referee must be an attorney.<sup>4</sup>

Following appointment of the referee, he or she must meet with the parties to the dispute, to assist them in preparing an “arbitration submission.” This document sets out the nature and scope of the dispute, including: (1) a clear and accurate statement of the matters in controversy; (2) an agreement as to the payment of the costs of the arbitration; (3) the procedure to be followed in the arbitration; (4) a list of the witnesses whose testimony is intended to be presented to the arbitrator; (5) the name of the arbitrator chosen by each party; (6) the time and place of the meeting of the arbitrators; and (7) any other matters that may be pertinent to the arbitration.<sup>5</sup>

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Once the arbitration submission is prepared and executed, the two arbitrators designated in the submission (one by each party) then must select the third arbitrator to sit on the panel. If there is more than one plaintiff, all of the plaintiffs together must agree on one arbitrator to "represent" them; this is also true in cases involving multiple defendants. Arbitrators must be impartial, "without favor or affection to either party" to the dispute, and this is ensured, under law, by having the referee obtain each arbitrator's sworn statement of impartiality.<sup>6</sup>

As indicated above, the arbitrators and the referee are compensated by the parties to the arbitration proceeding. In addition, the arbitrators may not be held civilly or criminally liable for libel, slander, or defamation of any of the parties to the arbitration, for any statement or action taken within the official capacity of the arbitrator during the arbitration.<sup>7</sup>

## The Arbitration Proceeding

Once the arbitration submission is filed, the parties to the arbitration are then authorized to undertake discovery "in the same manner as provided by law for discovery in civil cases in the superior courts."<sup>8</sup> In that regard, the referee is authorized to compel the attendance of witnesses, to issue subpoenas

requiring the attendance of witnesses, and to compel the parties to produce books and all other papers which may be deemed necessary and proper for the investigation of the matters submitted to arbitration.<sup>9</sup> At the arbitration hearing, examination of witnesses and the admission of evidence is governed by "the rules applicable to the superior courts."<sup>10</sup>

Upon the completion of the hearing, the arbitration panel must make written findings on each of the matters in controversy contained in the submission. Where all of the arbitrators do not agree on a particular point, a majority of the arbitrators are authorized to make the finding.<sup>11</sup> These findings are then provided to the parties and filed with the court and, unless appealed by either party, have the full force and effect of a judgment or decree of the court.<sup>12</sup>

## Appealing an Arbitration Award

Any party to the arbitration proceeding is authorized to appeal the findings of the arbitration panel, within 30 days, by filing a notice of appeal with the referee.<sup>13</sup> Thereafter, a hearing is held before the superior court which initially authorized the arbitration. This hearing is not *de novo*; the superior court does not substitute itself for the arbitration panel as the trier-of-fact. Quite the contrary, the superior court may

only overturn the decision of the arbitration panel on one or more of three narrow bases: The Court may only reverse the arbitration panel if the findings of fact (1) were procured by fraud, (2) are not supported by any evidence, or (3) are contrary to law.<sup>14</sup> In all other cases, the court must affirm the decision of the arbitration panel.

## Conclusion

As all tort reform proponents are well aware, the trial of a medical malpractice case may be a time-consuming and expensive proposition. Under current Georgia law, in appropriate cases, parties to a medical malpractice claim may choose to air their dispute in a different forum — by electing in writing to be governed by the Georgia statute authorizing the arbitration of medical malpractice claims.

## Notes

1. Acts 1988, pp. 903 *et seq.*, effective July 1, 1988.
2. See, e.g., Cole, "Health Care Litigation: The Arbitration Alternative for Dispute Resolution," *The Medical Staff Counselor*, Vol. 3, No. 1, Winter, 1989, pp. 35-42.
3. O.C.G.A. §9-9-62.
4. O.C.G.A. §§9-9-62, 66.
5. O.C.G.A. §9-9-65(a).
6. O.C.G.A. §§9-9-67, 69.
7. O.C.G.A. §§9-9-82, 83.
8. O.C.G.A. §9-9-72.
9. O.C.G.A. §§9-9-73, 74.
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## Treatment of Early Stage Vocal Cord Carcinoma

Gary Ayers, M.D.

***“The cure rates for early stage vocal cord cancer are excellent with primary radiotherapy. Voice quality remains as good or becomes better than prior to treatment.”***

**A**S USED IN THIS DISCUSSION, early stage vocal cord cancers are those included in the follow AJCC categories:

**T1NO** — Tumor confined to one or both vocal cords with normal mobility, including extension to anterior and posterior commissures.

**T2NO** — Supraglottic or subglottic extension of tumor with either normal or decreased vocal cord mobility.

This subclassification from more advanced cases of laryngeal carcinoma is important, because these early cancers have an excellent cure rate, and chances are good that normal voice quality can be maintained.

### Incidence and Treatment

**T**here are approximately 10,000 cases of laryngeal cancer in the United States each year, and many of these present as early stage cancers. Hoarseness is the most common complaint and occurs when the tumors are very small. Indirect laryngoscopy and biopsy are easily performed, but unfortunately many of these patients have had symptoms for months and have seen more than one doctor before a diagnosis is made. The single most important prognostic factor for all cancers is stage of disease at the time treatment is started.

Indirect laryngoscopy with a mirror is easy to learn, and *all* physicians should be able to perform it. Any patient who complains of hoarseness, particularly if longer than 2 weeks' duration, should have the vocal cords examined by this technique.

**T**he treatment for early stage vocal cord cancer may be either radiation therapy or surgery, and the cure rates are similar. Because there can be considerable differences in size and extension of tumors in each T-stage, it is important to compare similar lesions when comparing results of radiation and surgery.<sup>1</sup>

As a radiotherapist, my bias is naturally in favor of radiation treatment. However, there are some definite advantages to this treatment compared to surgery. With radiation, the quality of voice is likely to be better,<sup>2-4</sup> and an operation (usually cordectomy or hemilaryngectomy) is avoided. Also, the cost of radiotherapy is about half that for surgery for this particular situation.<sup>5</sup>

The dose of radiation required is in the range of 6,000-6,500 rads, given five times a week, over 5 to 6 weeks. The treatment is well tolerated, usually with only mild mucositis and skin erythema within the treatment field. Severe complications (requiring surgery) are rare, occurring in only about 1% of the cases.



**TABLE 1 — Local Control of Vocal Cord Cancer, By Stage and Method of Treatment**

	<i>Radiation Alone</i>	<i>With Surgical Salvage</i>
<b>T1</b>	<b>87-93%</b>	<b>94-98%</b>
<b>T2</b>	<b>68-75%</b>	<b>84-96%</b>

Local control is shown in Table 1 (minimum 2-year follow-up).<sup>1, 6</sup>

Of the patients who recur after radiotherapy, 70-75% can still be cured with surgery.

This would be the recommended approach to treatment for the squamous cancers, which account for a large proportion of these tumors. An exception might be the verrucous variety, for which surgery might be the initial treatment.<sup>2, 7</sup>

#### Summary

The cure rates for early stage vocal cord cancer are excellent with primary radiotherapy. Voice quality remains as good or becomes better than prior to treatment. For the local failures that do occur, surgical salvage will yield ultimate cure rates of about 95% for T1 and 90% for T2 tumors.

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# MRI UPDATE

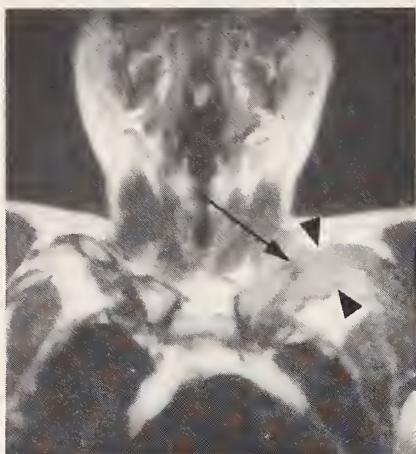


Figure 1

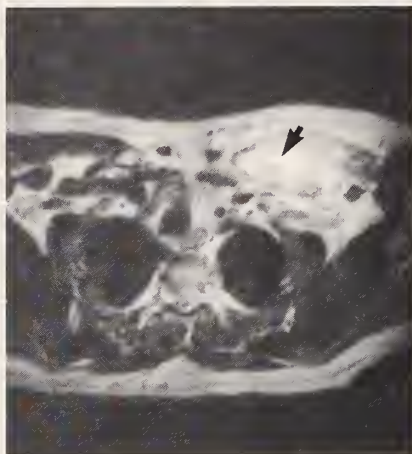


Figure 2

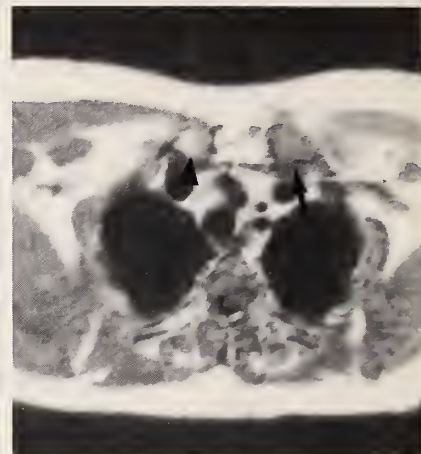


Figure 3

**HISTORY:** This patient is a 45 year old male who, on minor trauma, felt a popping sensation in his left sternoclavicular region. Diffuse swelling developed and progressed down the left anterior chest wall over the next few weeks. A CT scan demonstrated a fracture of the midportion of the clavicle with minimal asymmetry of the soft tissues.

**MRI FINDINGS:** Coronal images demonstrated disruption of the midportion of the left clavicle (Fig. 1, long arrow) with intermediate signal intensity material extending into the adjacent muscles (arrowheads). Transverse T2 weighted images

(Fig. 2) show an area of increased signal intensity in the region of the clavicular fracture with extensive intermediate signal intensity material extending into the surrounding muscles. The high signal area most likely represents a hematoma surrounding the fracture (short arrow). The more diffuse intermediate signal represents diffused blood and/or edema in the surrounding muscles. T1 weighted images (Fig. 3) demonstrated low signal in the region of the clavicle near the sternoclavicular joint (small arrow, compare to high signal of right clavicle, arrowhead). The low signal indicates a bone marrow replacing process. Given the

history of fracture following minor trauma, low signal intensity within the left clavicle increases suspicion of underlying malignancy rather than post traumatic edema. Biopsy showed undifferentiated carcinoma.

## MRI HIGHLIGHTS:

While the fracture and minimal asymmetry of the soft tissues can be identified on the CT scan, this case illustrates the superior soft tissue contrast differentiation of MRI. Changes that are difficult to appreciate on the CT scan become obvious on MRI, which is rapidly becoming the method of choice for evaluating occult soft tissue abnormalities.



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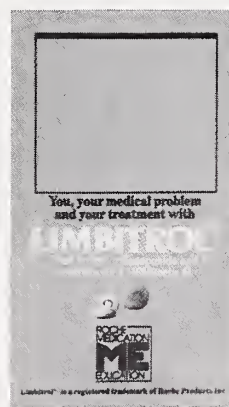
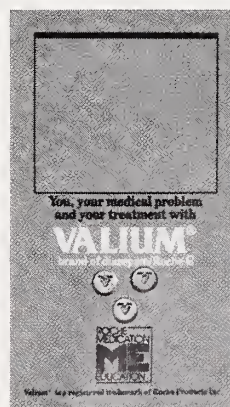
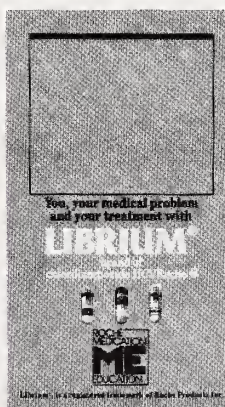
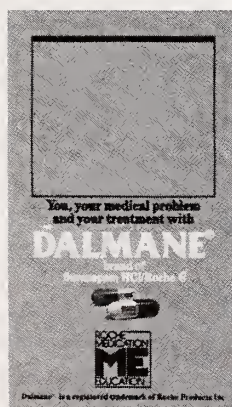


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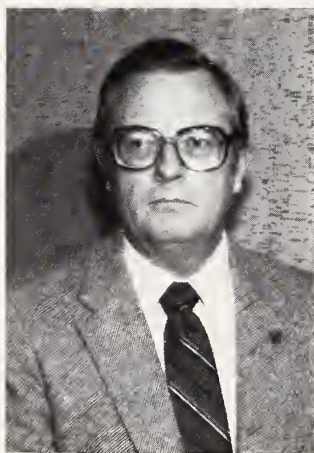
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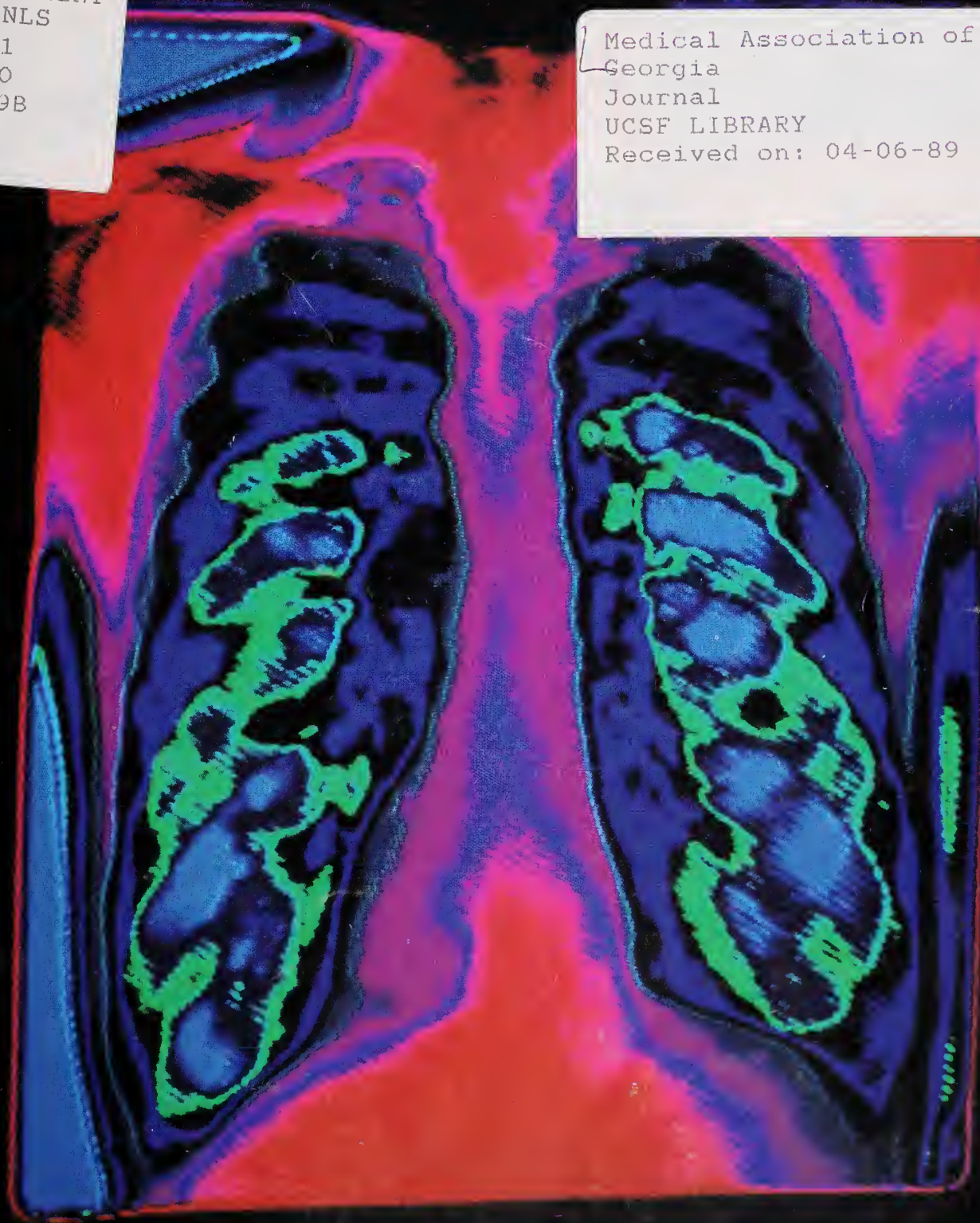
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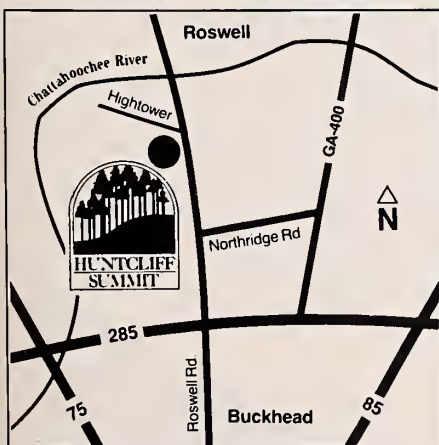
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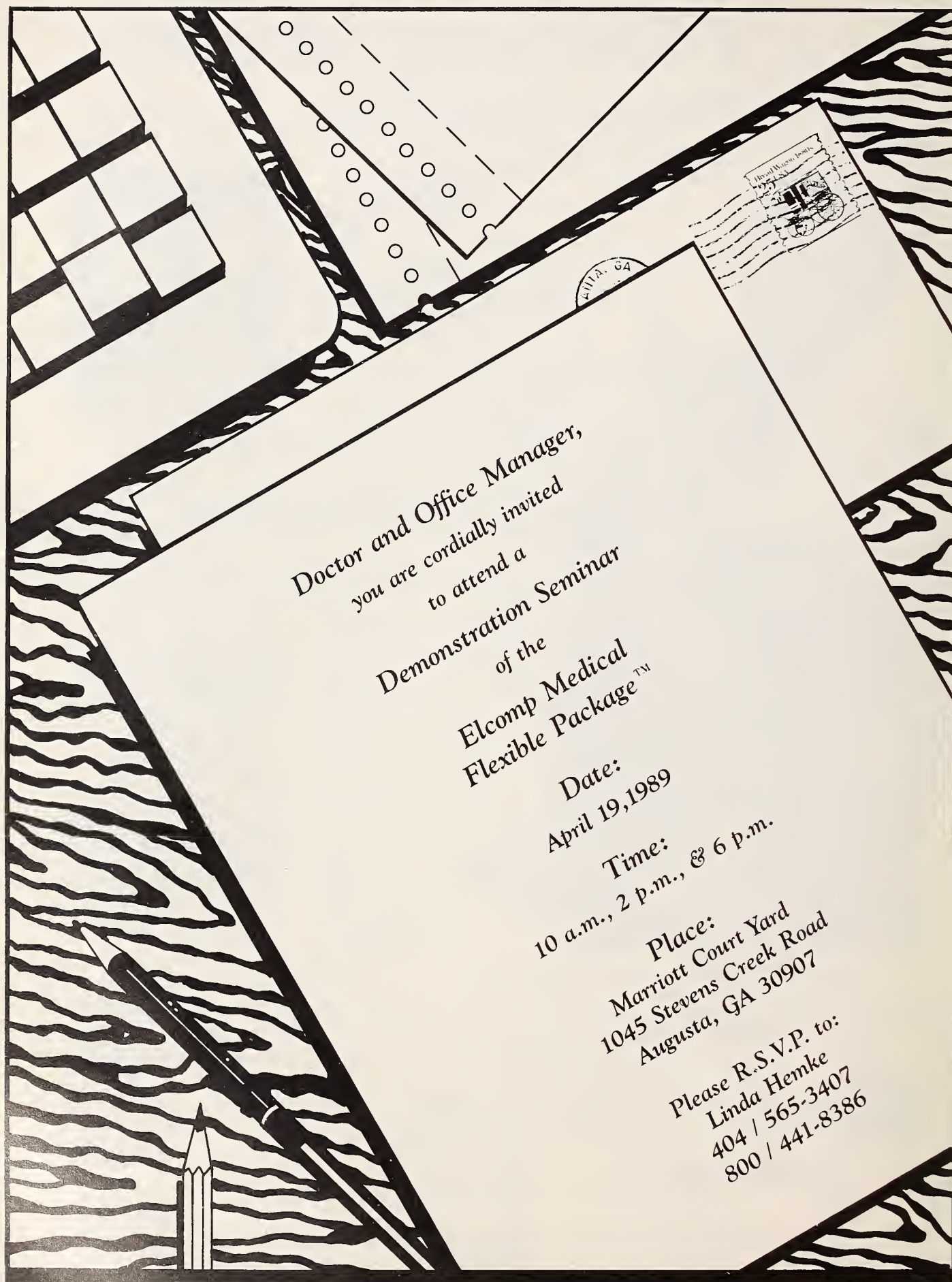
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**THE COVER**

Recognizing the radiologic manifestations of pulmonary complications associated with AIDS can help in the early clinical evaluation of these patients. Drs. Cooper and Kenny describe the radiologic variations in their article on p. 197.

Our cover art is a computer-enhanced tomography of the lung, taken by New York photographer Howard Sochurek.

# MRI UPDATE



Figure 1

**CLINICAL INFORMATION:** Non-meniscal abnormalities are commonly suspected and evaluated by MRI and unexpected non-meniscal abnormalities are commonly demonstrated in the course of MR evaluation for internal derangements of the knee.

**FINDINGS:** Figure 1 is a sagittal image through the lateral compartment of a 15-year-old patient's knee. The subarticular portion of the lateral femoral condyle is affected by low signal alteration containing three rounded areas of higher signal intensity. The findings here are diagnostic of osteochondritis dissecans (straight arrows). Notice the normal adjacent anterior and posterior horns of

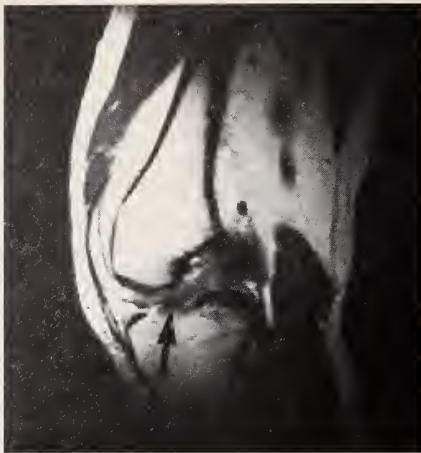


Figure 2

the lateral meniscus (curved arrows).

Figure 2 is a sagittal image through the intercondylar midportion of a 19-year-old patient's knee. The tibial insertion of the anterior cruciate ligament is indicated by the arrow. The remainder of the anterior cruciate ligament is totally disrupted and its expected position is occupied by inhomogeneous material of intermediate signal intensity compatible with hemorrhage. The anterior cruciate has been notoriously difficult to evaluate by MRI, but its reliable evaluation is now possible with careful positioning and rescanning of questionable cases.

Figure 3 is a coronal image of the posterior aspect of the knee



Figure 3

of a 33-year-old patient. The arrow indicates a 1.5 cm. ganglion cyst intimately applied to the lateral aspect of the biceps femoris tendon just proximal to the fibular head. The MR study clearly demonstrates the extra-articular and extraosseous nature of this process.

**COMMENT:** MRI has become clearly established for evaluation of internal derangements of the knee. Meniscal evaluation is known to be highly accurate. The cases shown here are meant to demonstrate the efficacy and accuracy of MR evaluation of extrameniscal structures.



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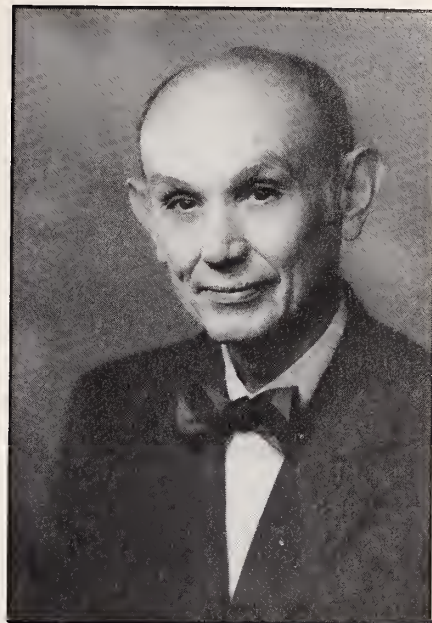
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*Joseph P. Bailey, Jr., M.D.*

### *What Is This Thing?*

**W**HAT IS THIS THING called the "Practice of Medicine"? It is certainly a thing that requires your undivided attention; a thing that requires half a lifetime of formal education and then a continuing educational effort almost as great; a thing that places your fellow human beings' lives in your hands; a thing that takes you away from your family; a thing that places you in judgment from all quarters; a thing that is a profession and almost a religion; a thing that requires intelligence, compassion, and very hard work, and a thing that makes you wonder sometimes just why you are doing it.

But it is a profession of the highest calling. It is an opportunity to bring something of value to your fellow human being. It is an opportunity to keep learning. It is a chance to do something that gains for you an element of self respect. It is truly the opportunity to have passed through this life having given of self with the end compensation being genuine satisfaction.

To each of you I extend my gratitude for your never ending positive effort.

*Joseph P. Bailey, Jr.*

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## SOCIETIES

### MAA Hosts Communications Workshop

Tom Sinkovitz, WXIA Channel 11 medical news reporter, was one of three representatives from Atlanta's medical media who spoke at the MAA Communications Workshop held at the Academy of Medicine last January. About 50 physicians attended the workshop, which was designed for doctors interested in working with the media.

The *Atlanta Journal/Constitution's* Steve Sternberg, a 14-year veteran of medical journalism, and WSB Radio's medical reporter Mike Summers were also on the program. Each reporter shared their thoughts and ideas on how physicians and medical reporters can best work together to deliver important news



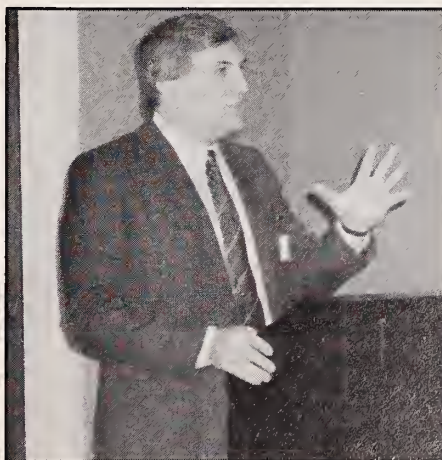


*More than 50 physicians attended the Medical Association of Atlanta's Communications Workshop last January to learn how to work more effectively with the media.*

about health and medicine to the community.

Martin Weisberg, M.D., of Philadelphia, was the workshop's keynote speaker. Dr. Weisberg's 10 years' experience on network-affiliated television and syndicated talk shows fueled a knowledgeable and entertaining lecture. His presentation was highlighted by a hilarious videotape showing outtakes of well-known network journalists flubbing their lines, primping before beginning their reports (unaware that they are already being filmed), and showing their tempers after too many takes.

Public Relations expert Ken



*Martin Weisberg, M.D., of Philadelphia, a practicing physician who also hosts a syndicated talk show, was the keynote speaker of MAA's Communications Workshop.*

Williams, owner of an Atlanta firm specializing in health care public relations, also spoke about the public image of physicians and their role as communicators.

An afternoon hands-on session gave physicians an opportunity to participate in mock media interviews that were conducted by Atlanta journalist and author Maxine Rock. The interviews were videotaped and played back to illustrate the dos and don'ts of a successful media interview.

Considering the positive response to the workshop, MAA plans to hold similar communications courses on an ongoing basis.



## PERSONALS

*Bartow CMS*

**Saunders Jones Jr., M.D.**, of Cartersville, was recently inducted as a fellow of the American Academy of Orthopaedic Surgeons.

*Bibb CMS*

**Miguel A. Faria, Jr., M.D.**, a neurosurgeon in Macon, was recently elected the 1989 Chief of Staff of the HCA Coliseum Medical Centers. Dr. Faria is a Magna Cum Laude graduate of the University of South Carolina and the Medical University of South Carolina in Charleston. Certified by the American Board of Neurological Surgery, he is Clinical Associate Professor of Neurosurgery at the Mercer University School of Medicine.

*Georgia Medical Society*

**Julia L. Mikell, M.D.**, has been installed as Chief of Staff at Candler General Hospital. Dr. Mikell practices with the Neurological Institute of Savannah, and is neurology medical director in Candler's rehabilitation unit and co-director of the sleep center.

*Dougherty CMS*

**Bernard P. Scoggins, M.D.**, was elected medical staff president and Chief of Staff at Phoebe Putney Hospital in Albany. An internist, Dr. Scoggins has been a member of the hospital's staff since 1979.

Also elected to staff positions were **L.H. "Chip" Moree, M.D.**, an anesthesiologist, as vice president; and **W. Carl Gordon, M.D.**, a surgeon, as secretary.

*Stephens-Rabun CMS*

**Linda J. Harrell, M.D.**, obstetrician and gynecologist, was certified as a diplomate of the



*James A. Kaufmann, M.D., an internist in Atlanta and Chairman of MAG's Council on Legislation, attended a private meeting with Vice President Dan Quayle in Palm Beach, Florida, to discuss medical issues. Mr. Quayle was in Palm Beach as part of his first domestic tour as Vice President.*

American Board of Obstetrics and Gynecology. She has been on the staff of the Toccoa Clinic since 1986.

**Russell Burken, M.D.**, was certified as a diplomate of the American Board of Dermatology. Dr. Burken also serves as Clinical Assistant Professor of dermatology at the Medical College of Georgia.

## MEDICAL STAFF NEWS

Six physicians who have been on staff at DeKalb General Hospital in Atlanta for 25 years were honored for their distinguished service at a recent quarterly medical staff meeting. The physicians recognized include **Byron J. Hoffman, M.D.** (MAA), **Ellis B. Keener, M.D.** (Hall CMS), **Thomas F. Lowry, M.D.** (Decatur Seminole CMS), **Lamar McGinnis Jr., M.D.**, **Ronaldo R. Nodal, M.D.**, **Tom D. Raaen, M.D.**, **Robert A. Reich, M.D.** (DeKalb CMS). These physicians have been on staff since 1963.

## DEATHS

*Walker-Catoosa-Dade*

**John W. Acree, M.D.**, a family physician from Towns County, died recently at the age of 64. He had been in failing health since suffering a stroke last year.

Dr. Acree, who obtained his degree from the Medical College of Georgia in 1953, came to Towns County from Gordon County, Georgia, following a period of service in the U.S. Army and an internship and general practice residency at Macon Hospital.

In 1962, Dr. Acree was elected to the state legislature where he served two consecutive terms.

In 1971, Acree served on a committee to investigate the possibility of adding a badly-needed nursing home to the Towns County Hospital and the county's first nursing home became a reality in May 1971.

In 1975, Dr. Acree was appointed to the hospital's governing board and served in that position until 1984. He was honored in ceremonies at Towns County Hospital in May, 1986, when the adjacent Wellness Center was named after him.



# HELPING TO ACHIEVE THE FOUR GOALS<sup>1</sup> OF ANTIHYPERTENSIVE THERAPY...



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**CARDIZEM® SR**  
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**CONTRAINDICATIONS**

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

### WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction  $24 \pm 6\%$ ) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in some cases, but probable in some. (See PRECAUTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Dermatological events** (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

**Drug Interaction.** Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment,

may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

**Beta-blockers:** Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

**Cimetidine:** A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

**Digitalis:** Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

**Anesthetics.** The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing. The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system; these include any adverse reactions seen in angina studies that were not observed in hypertension studies. In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie, greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%).

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Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)
ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
somnolence	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) or have been observed in angina trials. In many cases, the relation to drug is uncertain.

**Cardiovascular:** Angina, arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.

**Nervous System:** Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor, abnormal dreams.

**Gastrointestinal:** Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT, and LOH (see hepatic warnings), vomiting, weight increase, thirst.

**Dermatological:** Petechiae, pruritus, photosensitivity, urticaria.  
**Other:** Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarthralgia pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

**References:** 1. Staessen J, Fagard R, Lijnen P, et al: *Pract Cardiol* 1986;12(5):55-65. 2. Massie B, MacCarthy EP, Ramanathan KB, et al: *Ann Intern Med* 1987;107(2):150-157. 3. Weir MR, Josselson J, Giard MJ, et al: *Am J Cardiol* 1987;60:361-411. 4. Frishman WH, Zawada ET Jr, Smith LK, et al: *Am J Cardiol* 1987;59:615-623. 5. Pool PE, Seagren SC, Salel AF: *Am J Cardiol* 1985;56:86H-91H. 6. Pool PE, Seagren SC, Salel AF: *Cardiol Board Rev* 1986;3(10):77-91. 7. Sunderrajan S, Reams G, Bauer JH: *Hypertension* 1986;8:238-242. 8. Amodeo C, Kobrin I, Ventura HO, et al: *Circulation* 1986;73(1):108-113. 9. Schulte K-L, Meyer-Sabellek WA, Haertenberger A, et al: *Hypertension* 1986;8:859-865.

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## The Experience

*This month's Editor's Corner is a repeat of the one that originally appeared in the October, 1988, issue of the Journal. On the eve of the 1989 Annual Session of the MAG and the attendant presidential election of the organization, it is felt to be appropriate.*

I THOUGHT THE OTHER DAY of what I had been told of changing a light bulb in California. "How many people does it take?" "Three. One to hold the ladder, one to change the bulb, and one to savor the experience."

That's the way it was with the Democrats and their gathering in Atlanta this past summer. I had thought that one could read about it. Lord knows enough printer's ink flowed onto paper in doing so. If not, the "visual media" flooded the airwaves to the point of tedium.

Wrong! Remember Thou the light bulb! Should one with serious intent wish to accurately grasp this accumulation of issue-motivated fellow beings, then he or she must have *experienced* it.

I had said to myself all week that the sheer convenience of the Thing made a visit into town a necessary effort in the ever continuing task of not missing anything in this one way trip through life. And so we went, we political inactivists, into the maw of the city. It was a day of magic — warm with summer sun, dry from lack of rain, wet as time

passed into evening and thus possessed with the same unpredictability of the trip into town.

We got there on MARTA. Remember, the Metropolitan Atlanta Rapid Transit Authority. It's a bit like the Massachusetts Transit Authority (MTA). Too young for the Kingston Trio? Too bad. They wrote, and sang, a little tune called "Riding on the MTA." It's a happy little song about a fellow who got on the MTA and just kept riding round and round the endless tracks, being handed necessary supplies — sandwiches and the like — as he traveled by friends waiting in the station.

We should have done it. Gone round and round, that is. But, we exited at the Five Points Station. Up the escalator to great throngs of placard-bearing, flag-waving, button-festooned delegates, all espousing a personally held view of the manner in which grave matters of universal concern should be viewed.

"Save The Babies."

"Nuke 'em."

"Get 'em Duke."

"Gays Have Rights, Too."

"Save Our Forests."

"Women Against Ladies."

"Fetuses Have Rights, Too."

Dear Lord, preserve us — "Docs For The Duke."

They were all there: the radical right, the radical left, the radical middle of the roaders, the "I think this," the "I think that," the "I am not sure what I think." Everyone was present.

**‘In May, 1989, we shall choose that person who will be our President. . . . Does our candidate understand the issues? . . . Will he make a desirable and impressive representation of MAG to the public? 9**

And there in the midst of the swirling, sweating, professing mob stood I. What did I believe? Who did I really think would make the best President of the Republic? Was abortion an issue at all? Were the Irrational Iranians worth worrying about? Is the deficit really a problem or a fiscal mirage? Do I *really* give a damn anyway?

I walked the streets, inhaled the odors, tasted the indecision, and gazed at the ever-changing vista. I tried with no success to remember what the last GaMPAC-AMPAC epistle said — something about involvement in the political process — contribute, vote. I tried, oh, how I tried, to *experience* it all.

It was soon over. We settled into the crowded MARTA train. Eight-five cents from Peachtree Station to the Arts Center Station. Quite a change, mind you. Political chaos to artistic chaos.

But, out of the central city at last. Out of the turmoil into the quiet and peace of the cultural oasis that Bob Woodruff had helped give to the City.

**W**here are we in this never-ending quest for consensus building in the nation? Are the PACS truly effective? Do they convey to those they represent a fair return on investment for influencing the decisions upon those matters of interest to them? Do political conventions, as in Atlanta and New Orleans this summer, provide a method of expressing the will of the people or are they but a gathering of influence seekers and media elite? My conscious self found itself but little helped by the throng of people espousing a personally held view toward the myriad issues in question. Was I so ingrained, so rigid, with preconceived notions that no amount of persuasion could sway or impact them?

Well, we got out of it all right — home to peace, the papers, the T.V., the indecision. Home to ponder the *experience* in the days that followed. Home to ask myself if the person who had with singular effort brought his home state hazardously close to a socialized state of medicine as had any governor in the nation, racing ahead of those liberals of national stature we had so long feared and opposed, could he safely and effectively lead us into areas equally as threatening to our safety if not our survival?

There were in Atlanta that day many who thought him possessed of such talents and capable of such feats. I wondered.

**W**e face a similar decision-making process ourselves, we of the Medical Association of Georgia, for in May, 1989, we shall choose that person who will be *our* President. We will make a choice — for once in some time it will not be made for us — between two individuals seeking our presidency. Not so much flag waving, button festooning, or placard carrying surely, but nonetheless the questions we must ask ourselves appear strikingly similar to those I asked that afternoon in Atlanta. Does our candidate understand the issues? Will he be willing to or capable of reasonable compromise? Will he make a desirable and impressive representation of the MAG to the public? Will he pay attention to and consider my (our) feelings regarding issues, or with callous disregard armed with the power of office, plunge forward into the future with only his own concerns and opinions to guide him?

It seems to me that races, contested elections, are good for us. They show involvement, interest, concern, and a hundred other virtues which the unconcerned care not to experience. They force us out of the listless doldrums and demand that we ask questions. They demand that we think. One of those two persons running for the

Presidency of MAG will be seen as you and I in the eyes of the public for an entire year. His choice of clothes will reflect *our* taste. The cars he drives will reflect *our* values of money. The issues he defends, or opposes, *our* feelings and concerns about those we serve and live amongst. The maturity, judgment, and compassion — the character — he exhibits will reflect *our* maturity, *our* judgment, *our* compassion, and *our* character. He will be us.

**S**urely, and with effort, must we think about it. But then, not too deeply. Perhaps more in the form of casual reflection. More akin to the random thoughts that rise from nothingness as one comes home from work well done and sits to savor the first cool dusk of fall. Thinking can be dangerous. Joseph Conrad knew that. He told us in the preface to his novel, *Victory*.

*"... self assertion, ... the mere way of it, the trick of the thing, the readiness of mind and the turn of the hand that come without reflection and lead the man to excellence in life, in art, in crime, in virtue and for the matter of that, even in love. Thinking is the great enemy of perfection. The habit of profound reflection is the most pernicious of all the habits formed by the civilized man."*

CRU



## *A New Section Faces New Problems*

*William B. Jones, M.D.*

**“MEDICAL STAFF DEVELOPMENT”** — sounds innocuous enough. The purpose was to develop a committee at the local level to determine the physician manpower needs, both by number and speciality, and take steps to fill those needs. By this mechanism, patients would not bypass our town because of inadequate services. The sophistication and influence of the physician community would increase, the hospitals would remain financially healthy, and the whole region would benefit. This was mother and apple-pie material. Who could object?

On closer inspection, however, this plan, which was noble in its conception, could become a disaster in execution. The “committee” was to be composed exclusively of non-physicians from the hospital. Once the needs were established, this committee, without physician in-put, would recruit the needed physicians and determine which groups each particular physician would practice with. Physicians moving into town would not be given hospital privileges based on their qualification, but on the hospital’s perceived needs. By implication, renewal of existing physician hospital privileges would be based on patterns of hospital utilization. We were told that it was essential to have no physician in-put to avoid anti-trust

problems. In fact, a nationally known law firm which specializes in helping hospitals meet their manpower needs, was brought in to facilitate the whole process.

Here was a well meaning concept that very easily could have resulted in the physicians becoming de facto employees of the hospital. Indeed, it was the contention of the law firm that the medical staff was no different from the nursing staff, and held appointment completely at the leisure of the hospital governing board. But the administration had all the organization, and the change seemed a foregone conclusion. Physician reservations were felt to represent unwarranted paranoia. Things seemed to be moving too fast. What could concerned but busy physicians do either to clarify or eradicate their anxiety?

**T**urn to the hospital medical staff section (HMSS). This organization, formed in 1983 to address increasing potential economic conflicts between administration and medical staff, is extremely active nationally, but has been moribund in Georgia. Georgia, in some ways, is fortunate in lagging behind the nation in the number and intensity of increasing hospital/physician conflicts. Many areas of the country have, through the

HMSS, well-established mechanisms to prevent these conflicts or satisfactorily resolve them when they arise.

With the “medical staff development” situation just described, Dr. Howard Lang, President of the national HMSS was called, and through his experience and contacts, it became clear that the physicians’ potential concerns were in fact very real. Legal counsel for the California Medical Association was then contacted for possible responses. Through that counsel, we learned that an expert in hospital/staff conflicts was in our own backyard, Mr. Richard Vincent, an attorney in Atlanta.

Mr. Vincent came to our Medical Society meeting and educated our members regarding the implications of the proposed plan. When the hospital administration was aware of our concern, the whole plan was shelved. In fact, due in part to this conflict, new channels of communication have been opened between administration and medical staff, which can both address the hospital’s legitimate needs while not impinging on the physicians’ ability to practice medicine.

**A**lthough the immediate cause of this conflict was poor communication between the hospital medical staff and the administration (for in its concept, the plan was essentially

Dr. Jones is a urologist and chairman of MAG’s Hospital Medical Staff Section. His address is 660-G Lanier Park Dr., Gainesville, GA 30501.

worthwhile), there is a much deeper problem. The change in health care financing has forever changed the way medicine will be practiced in America. This change occurred in 1983 when the U.S. government switched from a retrospective, cost-plus system, to the prospective reimbursement system.

**‘Although the immediate cause of this conflict was poor communication between the hospital medical staff and the administration (for in its concept, the plan was essentially worthwhile), there is a much deeper problem.’**

With the institution of the Diagnostic Related Grouping (DRGs), hospital revenues from its larger payer (Medicare) have steadily decreased. Because of the seemingly unquenchable thirst for health care in America, non-governmental third party payers have seen their insurance costs soar. They too have taken measures to switch from in-patient to out-patient care wherever possible, thus further decreasing hospital income. Managed health care plans have increasingly forced hospitals into signing agreements that have further decreased their margins. Technology has increasingly moved once exclusively in-patient tests and procedures to office-based ones. And, don't forget about the 37 million Americans that are uninsured but who continue to show up with

amazing regularity at the steps of the hospital. Is it any surprise that for the last 6 years the number of hospitals closed for financial reasons has steadily increased? A total of 81 community based hospitals closed in 1982, two of them were in Georgia (we have been made aware of two possible closures in Georgia already this early in 1989). The private payers will only get tougher. The logic of the huge federal deficit dictates further cuts in Medicare reimbursement as the utilization of this group continues to increase. The continued shake out in the managed health care field will only lead to further economically questionable deals. The term "frantic" would not be inappropriate to describe the situation of the hospital industry.

Their very survival, in truth, is at stake. And, as a drowning man understands he must grasp at any object, however futile, the

**‘The continued shake out in the managed health care field will only lead to further economically questionable deals. The term *frantic* would not be inappropriate to describe the situation of the hospital industry.’**

hospitals increasingly have to act this way as their financial solvency slowly declines. But we, as physicians, cannot afford to let this happen. Which among us can practice without a hospital? Which of us would want to practice in a marginal hospital which could not provide us with

the latest technology? As hospitals suffer, so will we and our patients. The problem is to balance the hospitals' need for a stable revenue base with physician independence.

**‘As originally organized, the Georgia chapter of the Hospital Medical Staff Section has been a failure. In part, this was due to the statewide IPA which usurped many of its functions.’**

Physicians need to be actively involved in the hospitals' financial well-being but not at the expense of their freedom. We feel that the solution to this problem will be pluralistic, each community adjusting and flexing as seems appropriate to the local situation. This is where the state HMSS comes into play. In some areas of the state, these conflicts will be minimal, and in these the HMSS will be dormant. In most, however, it is felt that the above increasing financial pressures will lead to conflicts in which administration and physician will be opponents rather than partners. By adequate physician involvement, we hope to minimize the occurrence of such conflicts. By organizing our members under the HMSS, we will be able to rapidly address issues of concern that do arise and consider possible solutions.

As originally organized, the Georgia chapter of the HMSS has been a failure. In part, this was due to the statewide IPA which usurped many of its functions. Although it is still active, the IPA no longer appears to be the ideal



conduit for the task at hand. At the latest MAG Board of Directors meeting, the Hospital Medical Staff Section was reorganized into an Ad Hoc Committee, and I was named with myself chairman. The Committee will be composed of physicians throughout the state who will serve as a monitor of hospital/staff relations in their respective communities and serve as a resource for conflict resolution when such arises. Their ability to provide options will grow from the contacts with the HMSS on a national level, as these members will be encouraged to take part in the bi-annual HMSS meetings which are held concurrently with the AMA annual and interim meetings. In addition, a report on various state and national HMSS activities will be published quarterly in the *MAG Journal* and more frequently as needed in the MAG Newsletter.

**‘MAG’s newly organized Hospital Medical Staff Section will be composed of physicians throughout the state who will serve as a monitor of hospital/staff relations in their respective communities and serve as a resource for conflict resolution when such arises.’**

Also, periodical points of interest will be sent to the Chief’s of Staff throughout the state as well as to the members of this Committee.

It is not the intent or purpose of

the HMSS to serve as a mechanism to block any and all hospital efforts to enhance their business. Rather, this organization hopefully will aid those efforts that provide for economic stability of the hospitals while protecting physicians from unwarranted and non-productive intrusions into their areas of responsibility. Examples of such endeavors include joint ventures for out-patient diagnostic equipment or physician office buildings.

The membership of the Committee is being drawn up at this time. If you, or anyone you know, might be interested in serving, please contact Cam Taylor at MAG Headquarters. I can’t think of a better way to quickly get into action than planning to attend the up-coming national HMSS meeting to be held in Chicago this June.

Let’s get to work!

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# CALENDAR

## APRIL

22-23 — *Augusta: Pathology Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

29-30 — *Atlanta: The Cardiac Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## MAY

1-6 — *Augusta: 24th Annual Primary Care and Family Practice Symposium.* AMA Category 1 credits and AAFP Prescribed credits. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

4 — *Atlanta: Soberfest Conference, "Alcohol and Drug Abuse: A Day with the Experts."* Category 1 credit. Contact Susan E. Pajari, Willingway Hospital, 311 Jones Mill Rd., Statesboro 30458. PH: 912/764-6236.

5 — *Statesboro: Soberfest Conference, "Alcohol and Drug Abuse: A Day with the Experts."* Category 1 credit. Contact Susan E. Pajari, Willingway Hospital, 311 Jones Mill Rd., Statesboro 30458. PH: 912/764-6236.

18-20 — *Jekyll Island: Georgia Rheumatism Annual Meeting.* Category 1 credit. Contact Richard S. Field, M.D., Section of Rheumatology, MCG, Augusta 30912. PH: 404/721-2981.

19-21 — *Destin, FL: Georgia Radiological Society Annual Meeting.* Category 1 credit. Contact Lloyd B. Schnuck, Jr., M.D., 9 Medical Arts Center, Savannah, GA 31405. PH: 912/242-8090.

24-26 — *Calloway Gardens: Perinatology Conference.* (Sponsored by The Medical Center in conjunction with the Dept. of Pediatrics & Ob/Gyn.) AMA Category 1 credit, ACOG, AAFP, & PREP prescribed credits. Glenda Driscoll, 710 Center St., Columbus 31994. PH: 404/571-1692.

## JUNE

12-15 — *Hilton Head Island, SC: Clinical Cardiology.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

19-24 — *Kiawah Island, SC: 20th Annual Internal Medicine Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-25 — *Sea Island: GA Chapter, American Academy of Pediatricians.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., NE, Atlanta 30342. PH: 404/237-3922.

23-25 — *Hilton Head Island, SC: Daily Anesthetic Challenges.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

26 — *Atlanta: Breast Cancer: Conservative Treatment.* Category 1 credit. Contact Donna Cannon, HCA West Paces Ferry Hospital, 3200 Howell Mill Rd., Atlanta 30342. PH: 404/350-5600.

28-July 2 — *Nairobi, Kenya: 4th International Interdisciplinary Conference on Hypertension in Blacks.* Category 1 credit. Contact International Society on Hypertension in Blacks, 69 Butler St., Atlanta 30303. PH: 404/589-5810.

29-July 2 — *Kiawah Island, SC: Hematology – Oncology – Recent Advances.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## JULY

10-12 — *Kiawah Island, SC: Update in Gynecology.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

13-15 — *Kiawah Island, SC: Clinical Obstetrics.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-22 — *Kiawah Island, SC: 11th Annual Critical Care Medicine.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

24-26 — *Kiawah Island, SC: 12th Annual Pediatric Update.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## AUGUST

10-13 — *Hilton Head, SC: Georgia Psychiatric Physicians Association.* Category 1 credit. Contact Jim Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

## SEPTEMBER

15-17 — *Augusta: Clinical Psychiatry.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

21-23 — *Hilton Head, SC: Frontiers in Nutrition.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.



### Hospital Issues on the General Assembly's Agenda

The Georgia General Assembly is looking this year at a number of issues affecting the state's hospitals.

Of particular interest to hospital's serving large numbers of indigent patients is the Indigent Care Payment Bill (HB 597). If passed, the bill would make all counties liable for the cost of providing medical care to their indigent residents, including physician charges for emergency hospital care. All charges would be billed at the Medicaid rate, and county liability would be equal to no more than one mil of property tax. Counties would be able to contract with local hospitals to provide the required care.

Exemptions to the Open Meeting Law (HB 140) saw favorable action when a compromise bill received the endorsement of the Georgia Press Association. The compromise, which at press time had passed the House and the Senate Judiciary Committee, provides that hospital authorities would not have to disclose information that is "potentially commercially valuable."

The Senate passed a bill (SB 137) allowing hospitals with fewer than 50 beds to obtain certificates of need for renovation projects without the application of the bed-need formula. That exemption would apply only to projects that do not include the addition of new beds.

And a modification has been introduced (HB 715) to the consent to treatment statute that would allow adult children to consent to medical treatment for their parents if their parents are unable to give consent themselves.

### Medicare Payment Shortfalls Get Individual Congressional Attention

More than 50 representatives from Georgia Hospital Association (GHA) hospitals met in Washington, DC, last month with Georgia senators and representatives to garner support for the American Hospital Association's (AHA) "Resolve to Protect Medicare" resolution calling for an end to Medicare budget cuts in 1990. The visit was part of the AHA's annual meeting, and state hospital associations from around the country joined forces to recruit support for the resolution.

The GHA delegation presented petitions with some 20,000 signatures supporting the resolution, and at press time, six of the state's congressional representatives had signed the resolution as cosponsors.

Nationally, 36 senators and 177 representatives have now co-sponsored the resolution. Sen. Paul Simon (D-IL), the bill's main sponsor in the Senate, has stated that the time has come "to make prudent health policy decisions through the legislative process and not solely with a budget knife."

### Medicare Losses on the Increase

A new study prepared at the request of the Georgia Hospital Association shows a growing pattern of loss for the state's hospitals under Medicare.

Small hospitals having fewer than 100 beds, for example, saw a .05% loss in treating Medicare patients in 1986. The following year, that loss grew to 4.24%, with projections of a 6.94% loss for 1988 and a 9.6% loss in 1989.

Large hospitals are showing a similar pattern, according to the

study results. In 1986, Medicare payments to hospitals with 400 or more beds were 7.76% higher than the cost of treating those patients. But in 1987, that surplus had decreased to 4.28%, with 1988 expected to show only a .55% profit and 1989 a 3.39% loss.

### Indigent Care Accounts for a Growing Share of Hospital Expenses

The State Health Planning Agency (SHPA) reports that hospitals saw a 52% increase in unreimbursed indigent and charity care from 1986 through 1987. In 1986, says SHPA, unreimbursed care represented 2.3% of hospitals' total gross revenues, whereas in 1987 the amount rose to 3.1% after subtracting bad debts and contractual adjustments.

According to SHPA, Georgia's percentage of uninsured citizens (18.2%) is higher than the national percentage (17.4%). And those figures, says SHPA, so not include persons who are underinsured.

### Teaching Hospitals on Medicare's Hit List

The U.S. General Accounting Office proposes to cut hospitals' Medicare indirect education payments by one third, thus reducing payments to teaching hospitals by \$766 million in fiscal year 1989, by \$843 million in fiscal year 1990, and by \$1 billion the following year.

Such drastic reductions are expected to affect severely the nation's 1,300 teaching hospitals, particularly large urban hospitals that treat high numbers of indigent patients and provide specialized services.

## *Turning Point — Another Way*

**R**EGARDLESS OF OUR backgrounds, I believe that most young married couples believe that they will be the ideal couple who "will live happily ever after." Somehow, I seemed to think that the perfume would sit on the dresser and the dust would not. Life would be perfect forevermore.

We discussed the future and had a clear picture of having children "in a couple of years." I would put my nursing career on hold because by that time my engineer husband would be able to afford my staying at home to be a fulltime mother.

The thought of sterility problems never entered my mind. In fact, the thought of any problem in this "perfect marriage" never entered my mind.

When two years had passed, I had given no thought to a long-term career. Birth announcements came from friends, and I had even chosen the one I liked the best and would probably use.

**A**fter three childless years, I became concerned. I made an appointment with the best sterility specialist in the city. I was so confident that some "little" problem could be quickly fixed. I referred some of my friends to this wonderful specialist, and each of them thanked me when they announced that they were expecting a baby.

Days turned into months, and months turned into years as my depression began to interfere with the simple act of even going to our bridge club. It seemed that everyone was expecting a new baby or had just had one. Somehow I didn't even seem to fit in anymore. At the same time, nurse friends were taking maternity leave, and some people even asked if we didn't like children.

After 7 years and two spontaneous miscarriages, it was finally clear to me that having children was not probable. My gynecologist (sterility specialist) asked if I had considered adopting children.

This quickly offered "another way" to fix what wasn't perfect. However, when my husband and I had our first appointment with the social worker, we almost ran out the door and had to admit to each other that it was too frightening to follow through with.

Little was said about a family for several months. Later, we again went to an adoption agency and left knowing that adoption was an option for us.

**W**e applied to adopt a son on October 16 and were told that the process could take anywhere from 9 months to 2 years. Maintaining my optimism, I said, "Oh, that is all I want for Christmas this year." A son, our first child, was placed in our

home on December 16 of the same year.

Since that time we have adopted two other lovely children. This has made me more sure than ever before that there is a master plan for our lives and that achieving success is not necessarily as we initially planned.

This experience has also made me aware that there are many "bumps" in the road and probably no couple actually "lived happily ever after."

**O**nce I said to my husband, "I wonder why we were so afraid of adoption that first time we went to an agency." His calm answer was, "We would have gotten the wrong children." God's gifts to our lives came "another way." Now I know that some achievements take some effort on our part and that very little, if anything, comes in a perfect package. We even have dust on the dresser.

*A Georgia Nurse and Parent*

*We invite contributions to this Department. Please send them % the Journal, 938 Peachtree St., Atlanta 30309.*



# Becoming A Doctor: A Journey of Initiation in Medical School

by Melvin Konner, M.D., Ph.D.

390 pp, paperback \$7.95, New York, Penguin Books, 1988

I DID NOT LIKE THIS BOOK, but I could not put it down. In fact, I read it twice within a 4-month period. I read it the second time hoping my anger and disappointment were sufficiently reduced to allow me to review it with a little less passion. At least the time allowed me to focus on Dr. Konner's grudging acknowledgement that there are some very positive forces for change at work in American medical education. His dismissal of their potential becomes just another example of the author's grandiosity in judging the profession of medicine.

Dr. Konner is the Samuel Candler Dobbs Professor of Anthropology at Emory University. He has authored a number of other books including *The Tangled Wing: Biological Constraints on the Human Species*, which is a very readable account of the growing evidence of the power of biology in human behavior.

*Becoming a Doctor* is Dr. Konner's account of his experiences as a third and fourth year medical student at Harvard, a school not identified in the book. Why he ever became a medical student remains a mystery to me, although family influences and "an appetite for experience that exceeds the normal restraints of pride" are acknowledged.

The impact of this book is in the accounts of Dr. Konner's clinical rotations. While the experiences are very personal and

subjective and, I believe, not representative of the experiences or reactions of most students, they should be of concern, especially to those of us in medical education.

Surgery, anesthesiology, neurosurgery, pediatrics, obstetrics, gynecology, pathology, psychiatry, and medicine are the clinical experiences which fuel Dr. Konner's observations and descriptive encounters. While there are a few physician or resident heroes described, most physicians are pictured as arrogant, blustering, and/or dehumanizing, and denigrating or abusive of patients. Dr. Konner's experiences left him with very negative feelings about surgeons and a more positive regard for primary care physicians whom he regards as having some awareness of the psychologic, social, and spiritual dimensions of the human experience.

The basic science years he dismisses as "too many facts are being taught too thoughtlessly in too short a time." While the book does not focus on the preclinical years, Dr. Konner does note the 1984 Association of American Medical Colleges Report on the General Professional Education of the Physician which recommended less emphasis on test scores, fewer laboratory and lecture hours, development of independent learners, and recognition of the psychosocial aspects of medical care.

For the clinical years he simply

says the models for the medical student are wrong. By wrong, he means the role models are residents who are overworked, sleep-deprived, overburdened with responsibility, barraged by ever changing facts, and oppressed by the medical hierarchy.

Perhaps what he describes is Harvard today, but I doubt it. In fact, Harvard — along with Mercer, New Mexico, Rush, Michigan State, and 10 or so other schools in the United States — has instituted curricular changes in keeping with the 1984 Report on the General Professional Education of the Physician. In addition, several efforts are underway to improve the clinical education of physicians by a greater focus on the role of medicine in society, enhancement of the doctor-patient relationship, shifting of primary care training to ambulatory settings, and requiring a period of community service.

Unfortunately, none of the positive changes are cited by Dr. Konner. There is, in fact, no evidence he looked for them. What is clear, however, is that Dr. Konner's anger at medicine and gift for descriptive writing has given this book more attention than it deserves.

It is not, according to the Ashley Montagu quote on the cover, "The most important book on medical education in almost 80 years." Physicians need to read it to understand why.

W. Douglas Skelton, M.D.  
Mercer University School  
of Medicine

# The Medical Association of Georgia's 1989 House of Delegates

Hyatt Ravinia Hotel  
Atlanta  
May 4-6

**N**EXT MONTH, the 135th annual meeting of the Medical Association of Georgia House of Delegates, our policy-making body, will be held in Atlanta at the Hyatt Ravinia Hotel, located north of the city at Interstate Highway 285 and Ashford-Dunwoody Road.

The House of Delegates is MAG's legislative body, charged by our Constitution with the responsibility for transacting all business of the Association. Most importantly, the House determines MAG's positions on current issues facing the medical profession in Georgia. And, as always, we will be electing MAG's President-Elect and other officers.

All members of the Medical Association of Georgia are cordially invited to attend the several sessions of our House and, with their elected Delegates and Alternate Delegates, to participate in discussion of the issues under consideration.

## Reservations for Lodging

Guest rooms at the Hyatt Ravinia Hotel are available for participants in our House meeting. All MAG delegates and officers have received reservation cards from MAG headquarters. All others must make reservations directly with the Ravinia reservation staff, preferably by calling the hotel at 404/395-1234. For this meeting MAG has secured a discounted room rate of \$96.00 single or double occupancy per night.

The Auxiliary to the MAG will hold its 64th Annual Meeting at the Hyatt Ravinia Hotel, May 5-6. Please refer to page 192 for program information.

A registration desk will be maintained in the Ballroom foyer of the Ravinia for delegates, alternate delegates, directors, and all members. The registration desk will be open:

Thursday,  
May 4 ..... 4:00 p.m. – 8:00 p.m.  
Friday,  
May 5 ..... 7:30 a.m. – 3:00 p.m.  
Saturday,  
May 6 ..... 8:30 a.m. – 4:00 p.m.

## Thursday, May 4 General Session

The opening General Session will be called to order by MAG President, Joseph P. Bailey, Jr., M.D. on Thursday, May 4, at 7:00 in the Ballroom.

After opening ceremonies, Dr. Bailey will present MAG Certificates of Appreciation to members who have made special contributions to MAG, and also to other citizens who have distinguished themselves in service to the medical profession in Georgia. The President will also honor MAG's members who have been in practice for fifty years or longer; those who have been awarded life membership; and those who have died during the past year.

Special events during this opening session will be the address of our annual Guest Speaker and the report of the Auxiliary to the Medical Association of Georgia by President Mrs. Jan Collins. Following will be the presentation of MAG's four special awards:

- Hardman Cup — presented to an individual for an outstanding discovery in medicine or surgery, or solution of a major problem in public health
- Distinguished Service Award — for meritorious service reflecting credit and honor to the Association
- Civic Endeavor Award — for outstanding public service and participation in civic activities
- Family Physician of the Year — the recipient of this award is determined by the Board of Directors of the Georgia Academy of Family Physicians.

## First Session of The House Thursday Evening

After these ceremonies, James A. Kaufmann, M.D., Speaker, will convene the House of Delegates at 8:00 p.m. in the Ballroom.

The order of business will include:

- nomination of candidates for MAG officers, AMA delegates and alternates.
- announcement of Reference Committees for Friday



- introduction of resolutions or other new business

### **Friday, May 5 GaMPAC Breakfast**

MAG's Georgia Medical Political Action Committee, GaMPAC, will sponsor a champagne breakfast on Friday morning, May 5, at 7:30 a.m. in the Ballroom.

### **Reference Committees**

According to the Bylaws of the Association, all resolutions and reports submitted by MAG officers, members county specialty societies, or committees which contain recommendations must be referred to a Reference Committee for open hearing.

All MAG members are invited to the Hyatt Ravinia Hotel and encouraged to appear and express their views before the Reference Committees. The Committees will open their hearings on Friday, May 5, at 9:00 a.m.

Our House customarily features 6 Reference Committees, each with an agenda of somewhat related issues:

- Reference Committee A (Maplewood "B" Room): socioeconomic
- Reference Committee B (Maplewood "A" Room): medical practice
- Reference Committee C (Camellia Room): legislation
- Reference Committee D (Azalea Room): medical education
- Reference Committee F (Oakwood "B" Room): MAG's budget
- Reference Committee C&B (Oakwood "A" Room): Constitution & Bylaws

### **Saturday, May 6 Second Session**

The Second Session of the House of Delegates will convene at 9:00 a.m. on Saturday, May 6, in the Ballroom.

Principal item of business will be consideration of reports submitted

by the several Reference Committees. The Delegates' vote on each of the numerous resolutions and recommendations brought before the House will help establish MAG's official policies.

Election of officers nominated on Thursday evening will take place during the Saturday morning session. The Tellers will pass out, collect, and count the ballots, and the results will be announced before the lunch break. All newly elected officers will be installed during the evening session on Saturday.

### **Installation of Officers Saturday Evening**

All Delegates, Alternate Delegates, Auxilians, Guests, MAG members and their spouses are cordially invited to the special ceremony for the installation of officers of the Medical Association of Georgia, Saturday evening, May 6, at 6:30 p.m. in the Dunwoody Room of the Hyatt Ravinia.

At that time, MAG's outgoing President, Dr. Bailey, will address the House and help install our new President, Joe L. Nettles, M.D., of Savannah. Dr. Nettles will deliver his inaugural address and, along with other officers of the Association, will take his official oath of office.

### **President's Reception**

The MAG and Auxiliary to the MAG will honor our Presidents, Dr. Joseph P. Bailey, Jr., and Mrs. Jan Collins, at a reception and dance beginning at 7:00 p.m., or immediately following the officers' installation on Saturday evening, in the Ballroom.

### **Sunday, May 7**

In the event that all Reference Committee reports are not acted upon in Saturday's session, the House will be convened at 9:00 a.m., Sunday, in the Ballroom.

### **Schedule at a Glance . . .**

#### **Thursday, May 4**

4:00-7:00 **Registration** (Ballroom Foyer)

7:00-8:00 **General Session** (Ballroom)

Presiding: Joseph P. Bailey, Jr., M.D., President

Opening Ceremonies

Report of the President of the Auxiliary to the MAG, Mrs.

Jan Collins

Presentation of MAG Awards  
Recess

8:00-10:00 **House of Delegates, First Session** (Ballroom)

Presiding: James A. Kaufmann, M.D., Speaker

and Jack A. Raines, M.D., Vice-Speaker

Nominations for Association Officers and AMA Delegates or Alternates

Review of House Agenda

Introduction of New Business  
Recess

#### **Friday, May 5**

7:30 a.m. **Registration** (Ballroom Foyer)

7:30 a.m. **GaMPAC Breakfast** (Ballroom)

9:00-3:00 **Reference Committee Hearings** (Azalea, Camellia, Maplewood, and Oakwood Rooms)

#### **Saturday, May 6**

8:30 a.m. **Registration** (Ballroom Foyer)

9:00 a.m. **House of Delegates, Second Session** (Ballroom)

Report of Reference Committees

Announcement of Election Results

6:30 p.m. **Installation of Officers** (Dunwoody Room)

Address of the President, Dr. Bailey

Address of the President-Elect, Dr. Nettles

7:00 p.m. **Presidents' Reception and Dance** (Ballroom)

# PROGRAM

## Auxiliary to the MAG

### 64th Annual Meeting

#### THURSDAY, MAY 4

- 3:00-5:00 **Registration and Information**  
 7:00 Opening Session of the MAG House of Delegates  
 A-MAG President's Report,  
 Mrs. William C. Collins  
 AMA-ERF Check Presentation

#### FRIDAY, MAY 5

- 9:00-5:00 **Registration and Information**  
 Hospitality and Exhibits  
 10:00 **Pre-Convention Executive Board Meeting**  
 (All former state presidents, state officers, state committee chairmen and members, county presidents and county presidents elect.)  
 12:00 **Auxiliary Luncheon**  
 (Executive Board, Delegates, MAG Committee on Auxiliary and guests.)  
 2:00 **Opening Session of the Annual A-MAG House of Delegates**  
 Call to Order  
 Spotighting County Presidents  
 Opening Ceremonies  
 President's Greetings  
 Introductions  
 Greetings from MAG President  
 Special Address  
**Business Meeting**  
 Introduction of Pages  
 Credential Report  
 Convention Standing Rules  
 Adoption of Program  
 Minutes  
 Officers and Committee Reports  
 Unfinished Business  
 New Business  
 Bylaws and Handbook Revisions  
 Announcements  
 Recess of Meeting  
**Exhibit Walk**  
 County Exhibits, Scrapbooks, Doctor's Day, Medical Heritage (Research & Romance of Medicine)

#### SATURDAY, MAY 6

- 9:00-12:00 **Registration**  
 Hospitality and Exhibits  
 9:00 **Second General Session, House of Delegates**  
 Introduction of Guests  
 Introduction of Past Presidents  
 Message from Southern Medical Association  
 Auxiliary, Mrs. Barbara Thibodeaux, President, SMA-A  
 Memorial Service  
**Business Meeting (Continued)**  
 Revised Credentials Report  
 Election of 1989-90 Nominating Committee  
 Election of 1989 A-MAG Delegates for AMA-A Convention  
 Report of Awards:  
 Achievement, AMA-ERF, Branwer  
 Certificates of Excellence, Doctors' Day, Membership, Safety, and Scrapbooks  
 Report of 1988-89 Nominating Committee  
 Election and Installation of Officers  
 Presentation of 1989-90 President's Pin and Gavel  
 Inaugural Address  
 Presentation of Past President's Pin  
 Announcements  
 Adjournment  
 12:00 **Luncheon**  
 (Newly installed state officers, outgoing officers, committee chairmen, committee members, county presidents, county presidents-elect, nominated presidents-elect, delegates, alternate delegates, auxiliary members and guests.)  
**Post Convention Executive Board Meeting**  
**Past Presidents' Luncheon**  
 7:00 **Presidents' Reception**  
 Reception honoring MAG President, Joseph P. Bailey, Jr., MD and A-MAG President, Mrs. Jan Collins.



## *The Demise of American Medicine?*

*John D. Watson, Jr., M.D.*

**H**AVE WE FINALLY REACHED that breaking point, whereupon the people of this nation and our government will say enough is enough, and we will have a universal health service? Have we, in our apathy and disregard of what is going on around us, allowed the system to devour us?

I feel we are closer to a National Health System today than at anytime in my lifetime. Why? Because of fiscal constraints — MONEY. The cost of Medicare, which exceeds \$80 billion per year, is escalating, and the professional sector is increasing at 15% a year. The most recent figures show the hospital portion, which is approximately 60%, is leveling off with DRGs. What is the next target — physicians?

Is there merit in this appraisal? Are we overutilizing the system? Are we allowing the excessive use of amenities for our patients, such as special beds, wheel chairs, bedside commodes — you name it — which must have physician approval? Are we gouging the system by performing repetitive tests far beyond what is necessary for good medicine? I have to contend that we are.

**I** looked at the emblem of the Medical Association of Georgia which displays a handshake. When I first noticed this many years ago, I was puzzled somewhat as to its

meaning. Then it became obvious to me that it meant physicians helping physicians take care of their patients. It did not mean a contractual relationship for monetary gain; rather it meant that, "I am available to help you, my brother or sister, in any way that I can to help your patient. I am here to help us all as an organized profession to support and promote the finest health care we can provide for the citizens of Georgia."

There was a time when attendance at the County Society meeting was an absolute must. To not attend was a sign of disloyalty to the profession. Look at us now. To not belong to the County Society, State Society, and the AMA was once considered not only to be disloyal but also to be an enemy of the Profession. Look at us now. We have a lot of gougiers, complainers, lounge orators, but do we have the support and cooperation that is necessary to function in the manner that is needed? You know the answer.

Are the rewards of this great Profession not enough through professional satisfaction? To save a child, to correct a surgical emergency, to reshape that limb for later life, and to help those who are terminal exit this life with dignity. Is this not enough, with a reasonable compensation for our services? There are precious few

**‘I suggest to you that if we do not return to our own individual practices and conform them to prudent practices, if they have been otherwise, we will suffer the wrath of the nation.’**

who are given the privileges that we hold — that of life and death, and freedom from pain and infirmity. Must we be in the "Business of Medicine" predominately for the monetary gain?

**T**here was a time when we were accused of not being willing to testify against each other, as we were so close and protective. Now, we see physicians as "hired guns," who are willing to sell their sacred trust again for monetary gain. Is it not enough to receive the awards from our labors within our own field of practice? Is it really necessary to get a piece of the action from each referral we make

Dr. Watson practices therapeutic radiology and is a Past President of the MAG. His address is P.O. Drawer 2787, Columbus, GA 31902.

to a certain diagnostic facility, or to a hospital in which we have a financial interest? Are we really that financially desperate?

I suggest to you that if we do not return to our own individual practices and conform them to prudent practices, if they have been otherwise, we will suffer the wrath of the nation. We will have legislation which will control us more severely than we would ever have imposed upon ourselves, although our own control would have been more palatable.

**‘If all of us cut one or two tests a day, the consequences of cost would be phenomenal, and the effect of health care would be miniscule.’**

Where is that camaraderie, where is that fraternity, where is that compassion, where is that satisfaction? I would suggest to you that financial needs, financial gain, and just plain greed are destroying us as a profession and will relegate us to a trade association shortly, and that will be appropriate. It will not be appropriate for our patients or the future of Medicine in our great nation, but it will be appropriate for those of us who have brought this upon ourselves. Would you like a 10%, 30%, or 70% cut in your income? How you practice, and how all of us practice, will have much to say in this decision. The dollar numbers are too evident. The deficit facing our government is too great not to

move in this direction. We must all examine our practices carefully and cut everything we can. We must not authorize expenditures that are not truly warranted. If there is a cheaper test that will give us the same information, we must use it. You may think this will not be meaningful, but I assure you it will. If all of us cut one or two tests a day, the consequences of cost would be phenomenal, and the effect on health care would be miniscule.

**T**ake your choice — control yourself now and your practice or look for that devastational control of your practice and your fees. I have not enjoyed writing this, but I felt compelled to express my opinion. The handwriting is on the wall, and the time is short. We still have a chance to make a change. I would add one more caveat. Those who believe that governmental medicine is coming and have adopted the philosophy that, “I am going to get mine while the going is good,” are merely feeding fuel to the fire and expediting the time when it may occur.

Let us reimburse that Sacred Trust we hold. Let us somehow renew our vows to SERVICE, COMPASSION, ETHICS, and most of all DEDICATION to the Profession. ■



## *Commentary on Surgery for Morbid Obesity*

*John Page Wilson, M.D.*

**T**HE COMPLETE EVALUATION of operations for morbid obesity, as for most operations, ultimately must include a number of very broad and philosophical questions and answers about health and intervention that exceeds the scope of this article. Therefore, certain assumptions must be made to address more immediately applicable concerns.

The question is not whether morbid obesity is bad but rather what can be done about it; not whether it is primarily a societal, sociologic, psychologic, or physiologic problem (it is undoubtedly some of all) but what do we know about it, what can we do about it in an effective way that eliminates the problems of obesity and does not create other problems, in a reasonably cost-effective manner?

**I**wish to address some remarks to the article by Dr. William Headley in the February and March issues of the *Journal*. The nature of obesity and its causes are complex and not completely understood at present and any approach must be made with the caveat that more knowledge may alter all approaches in the future. Therefore, only a few specific aspects of the questions pointed up in Dr. Headley's article will be addressed.

Dr. Headley has given us a well-documented, researched, and referenced discussion of the

problem. He has certainly raised most of the questions which have been attendant to these procedures, and he has also presented a specific approach. He presents a well-organized and executed program of bariatric surgery, with the all-important evaluation and continuing follow up. Some of the questions that he raises are unanswered because there are no answers at this time. Some of the answers given are subject to some differences of opinion. To those surgeons who are not intimately familiar with the procedures for bariatric surgery, he has clearly defined the outcome to be expected.

**I**t must be observed that the revision rate is high and that the more acceptable the procedure, the less effective it is in weight reduction. Vertical banded gastroplasty (VBG) does not return the patient below the 20% excess weight which Dr. Headley has indicated as the recognized point of increasing risk. A more detailed discussion of some of the unwanted or undesirable side effects or complications of the procedures would have been of interest and help.

Dr. Headley properly notes that bariatric surgery has not received "full acceptance" on the part of many surgeons. He notes a "prevailing view that obese patients simply lack willpower"

**‘Dr. Headley has done us all a service in sharing his experience with us. Time and effort has taught us that non-surgical measures of weight control have been far from satisfactory.’**

and could lose weight "if they really want to" and that weight loss is "uncommon and unpredictable." It could be suggested that there are probably a number of other reasons.

During the period when the evolution of the present VBG was occurring, the evolution of peptic ulcer surgery was proceeding in the opposite direction to eliminate the very consequences that bariatric surgery produces. It is difficult to suggest to surgeons taught through several decades of the undesirable sequelae of peptic ulcer surgery that these sequelae now are "desirable."

The patient's responsibility in obesity cannot be casually passed over. One of the concerns that

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many surgeons have had is that this surgery might be approached as a "quick fix." As Dr. Headley has indicated in the article, the current procedures for obesity (VGB and gastric bypass) are basically behavior modification procedures and his illustration of the mother and daughter point up this fact. There is simply no clear-cut line. Too, in the early days of doing jejuno-ileal bypass, one was frequently struck by the insistence of patients, literally dying of the consequences of their operation, that they be allowed to retain their bypass at all cost. Unquestionably, these patients would frequently tolerate discomfort and inconvenience far beyond that which most patients would.

Again, as Dr. Headley implied, in the early days and throughout the course of bariatric surgery, some bariatric surgery was done by those with limited skills and limited facilities in circumstances which would seem incongruous in this multifactorial disease with many high-risk conditions. Even after the evolvement of guidelines for bariatric surgery, these were extended and expanded beyond reasonable limits by some. As Dr. Headley again points out, patient selection is most important. It is extremely difficult, well beyond the specific guidelines relating to excess weight.

**H**aving discussed this with many colleagues, some of whom do bariatric surgery, the following conclusions can be drawn. In general, the surgeons who do bariatric surgery are keenly aware of their successes and those who do not are keenly aware of the failures. There is a place for bariatric surgery in selected patients, but the definition of these patients is difficult, individual, and not easily

**‘There is a place for bariatric surgery in selected patients, but the definition of these patients is difficult, individual, and not easily come by.’**

come by. Arbitrary parameters are not necessarily adequate indices for determining who needs the operative procedure. These are still basically procedures which need continued evaluation, that should be done in areas and by persons completely and fully dedicated and capable of carrying out the proper evaluation, surgical procedure, and necessary follow up.

Dr. Headley has done us all a service in sharing his experience with us. Time and effort has taught us that non-surgical measures of weight control have been far from satisfactory. With time and effort we should make progress against this complex and at times baffling problem and can hope ultimately to have a completely satisfactory resolution, possibly without the need for surgery.



# Pulmonary Complications in AIDS: The Radiographic Manifestations

Neil B. Cooper, M.D., William Kenny, M.D.

## Introduction

**I**N RECENT SPECIAL ISSUES of this *Journal*,<sup>1,2</sup> the subject of Acquired Immune Deficiency Syndrome (AIDS) was comprehensively covered. In an excellent article by Dr. Nahmias,<sup>3</sup> the detection and diagnosis of AIDS in the community at the primary care level was discussed. No mention was made, however, concerning the role of radiology as an adjunct to diagnosis. Chest radiography as well as barium studies, computed tomography, ultrasound, and nuclear medicine play an integral part in the work up of a patient with AIDS.

We wish to review the pulmonary complications and the associated changes seen on chest radiography. It is important to recognize these findings so that timely and appropriate diagnostic testing or therapy be instituted. The chest x-ray is sensitive to detecting early disease but quite nonspecific. Many of the opportunistic diseases have a similar appearance. Bacteriologic and histologic material must be obtained, as there are no pathogno-

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***P. carinii*, the most common pathogen, and several other opportunistic agents usually present with a fine bilateral interstitial or ground glass appearance.**

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monic radiographic abnormalities. Despite this limitation, recognition of the radiographic patterns of disease will help in earlier clinical evaluation of the AIDS patient.

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Dr. Cooper is with the Department of Radiology and Dr. Kenny is Medical Director of Respiratory Care, Department of Pulmonary, Piedmont Hospital, Atlanta. Dr. Cooper's address is the Department of Radiology, Piedmont Hospital, 1968 Peachtree Rd., Atlanta, GA 30309.

## Opportunistic Infection

Well over half of all AIDS patients will develop pulmonary manifestations during the course of their illness. The most common opportunistic pneumonia is due to *Pneumocystis carinii* which affects approximately 80% of patients at least once.<sup>4</sup> Symptoms of *P. carinii* pneumonia (PCP) include fever, non-productive cough, and dyspnea. Laboratory findings are nonspecific and may reveal lymphopenia and a low arterial oxygen content. While the diagnosis must be confirmed with induced sputum, bronchial lavage, or transbronchial biopsy, the chest film is nearly always abnormal at the time of presentation. The typical radiographic findings are bilateral perihilar or lower lobe reticular or reticulonodular infiltrates. The infiltrate has a fine or medium interstitial pattern, fairly symmetric, and described as having a "ground glass" appearance (Figure 1). Following drug therapy, the chest film usually clears in 2 weeks, although a rapid progression to bilateral alveolar consolidation may occur.

Unfortunately, up to 50% of cases of PCP may present with an atypical roentgenographic appearance. This includes unilateral infiltrate, upper lobe disease simulating TB and rarely, diffuse air filled cystic spaces. These pneumatoceles or air cysts can rupture, and the individual may present with a spontaneous pneumothorax.<sup>5</sup> Pleural effusion and hilar adenopathy are very unusual in uncomplicated PCP. The presence of either should suggest an etiology other than *P. carinii* such as TB or Kaposi's sarcoma.

Approximately 5% of patients with PCP have a normal chest radiograph. In these instances, when there is a high degree of clinical suspicion but no abnormality on chest film, gallium lung scanning can be useful for further evaluation (Figure 2). When the pulmonary uptake of tracer activity is equal to or greater than the activity in the liver, the diagnosis of PCP can be made with a high degree of accuracy. The lung scan in this setting is 100% sensitive and 90% specific.<sup>6</sup> Patients with a positive lung scan should undergo bronchoscopy to document PCP prior to therapy.

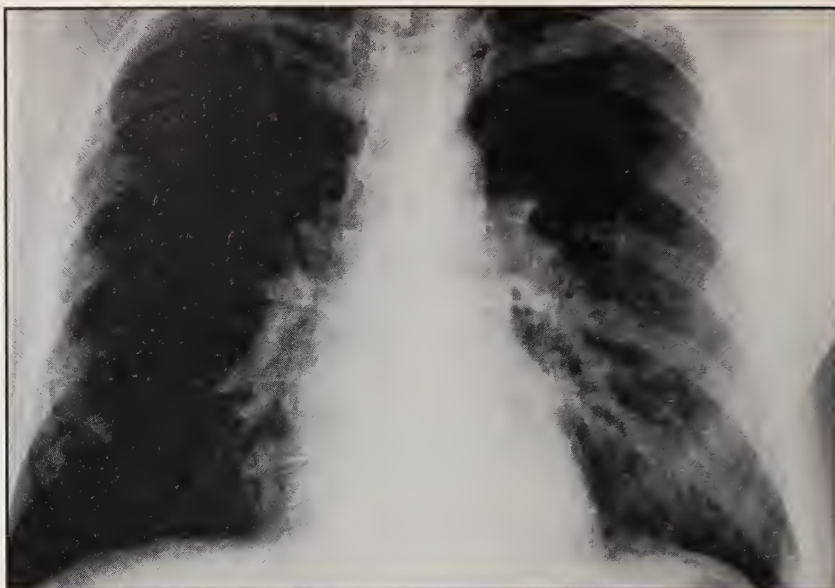


Figure 1 — *Pneumocystis pneumonia*. Note bilateral fine perihilar infiltrates.

**T**here is a high prevalence of cytomegalovirus (CMV) infection in AIDS patients, and it is the most ubiquitous infectious agent found in autopsied AIDS patients. In the lung, CMV is commonly found in association with other patho-

gens. Radiographically, CMV pneumonia cannot be distinguished from other opportunistic infections. Symmetric bilateral perihilar interstitial infiltrates indistinguishable from PCP marks the radiographic appearance. In some instances, CMV is more nodular than PCP.

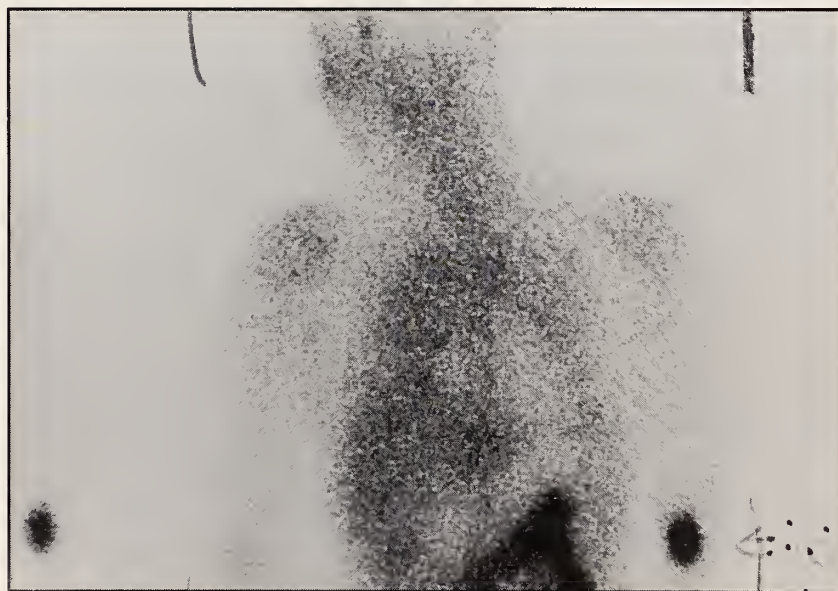


Figure 2 — Abnormal lung uptake in patient with *Pneumocystis pneumonia*.

**S**everal mycobacterial species are encountered in the AIDS population. The most common is *Mycobacterium avium-intracellulare* (MAI), occurring in up to 20% of cases. MAI is usually widely disseminated at the time of presentation. As with many of the opportunistic agents, MAI frequently coexists with other pulmonary disease (Figure 3).

In the immunocompetent host, MAI infection is primarily a pulmonary process causing nodular infiltrates that cavitate. Infection occurs in elderly patients with chronic obstructive pulmonary disease. In the immunocompromized patient, the radiographic findings are nonspecific and differ from the typical pattern. Findings range from a normal chest x-ray to mediastinal adenopathy, patchy bilateral infiltrates, and/or bilateral patchy nodules.<sup>7</sup> A miliary pattern or cavitation is rare. In the presence of medias-



trates, and/or bilateral patchy nodules.<sup>7</sup> A miliary pattern or cavitation is rare. In the presence of mediastinal adenopathy with or without a patchy infiltrate, a high index of suspicion for MAI should be maintained. Infection is confirmed with sputum culture or bronchoscopic washings.

*Mycobacterium tuberculosis* has been isolated from AIDS patients and occurs in roughly 10% of cases. At the time of presentation, the infection involves extrapulmonary sites up to 50% of the time.<sup>8</sup> Wide dissemination is less frequent, however, with TB than MAI. The radiographic appearance simulates that seen with primary TB, though the mechanism is probably reactivation. Mediastinal and hilar adenopathy in association with non-cavitary upper or lower lobe infiltrates are the hallmark findings. Unfortunately, the radiographic picture may simulate other opportunistic infections with a diffuse fine reticulonodular bilateral infiltrate. Upper lobe disease and cavitation are very unusual. Again, the diagnosis depends on sputum culture or bronchial washings, but in a patient with mediastinal adenopathy and pulmonary infiltrate, TB must be suspected.

**N**ot all infiltrates represent opportunistic infection. Common bacterial pneumonias occur with increased frequency in hospitalized AIDS patients compared to the immunocompetent host. Overall, there is an increasing incidence of bacterial infections in AIDS. A bacterial pneumonia presents with the typical lobar fluffy consolidative appearance on chest x-ray. Pneumonia may be caused by *Hemophilus*, *Streptococcus*, *Pneumococcus*, *Klebsiella*, *Legionella*, or any of several other pathogens. The presence of a focal lobar consolidation is unusual for PCP and should alert one to the possibility of an underlying bacterial pneumonia.

**F**inally, while fungal infections are common in the GI tract and CNS, infection in the lung is unusual. Fungal pneumonia occurs in less than 5% of the AIDS patients. A variety of fungi have been reported to involve the lungs including *Histoplasma*, *Cryptococcus*, *Coccidioides*, and *Candida*. The

chest radiograph is nonspecific, with bilateral interstitial or alveolar infiltrates being the most common appearance. The occurrence of histoplasmosis and coccidioidomycosis is greater in persons living in endemic areas. Occasionally, a miliary pattern is seen with disseminated *Histoplasma*. *Cryptococcus* may produce bilateral pulmonary nodules usually in association with brain or meningeal involvement.

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**Radiology has a pivotal role in documenting various opportunistic complications so that further testing and therapy may be instituted.**

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**A**n increasing number of individuals with symptoms indistinguishable from opportunistic infection are being discovered to have a nonspecific interstitial pneumonitis. While PCP is still more common, up to one third of AIDS patients may have nonspecific interstitial pneumonitis.<sup>9</sup> Radiographically, features are similar to PCP with bilateral interstitial infiltrates. Histologically, no causative agent has been isolated. If interstitial infiltrates fail to clear following drug therapy, nonspecific interstitial pneumonitis should be suspected. Bronchoscopic diagnosis is difficult, and open lung biopsy may be necessary.

#### Neoplasms

About 25% of AIDS patients develop Kaposi's sarcoma (KS). This is a multicentric process with involvement of lymph nodes, liver, spleen, the GI tract, and to a lesser extent the lungs. Pulmonary disease occurs in 20% of persons with KS. Patients usually already have

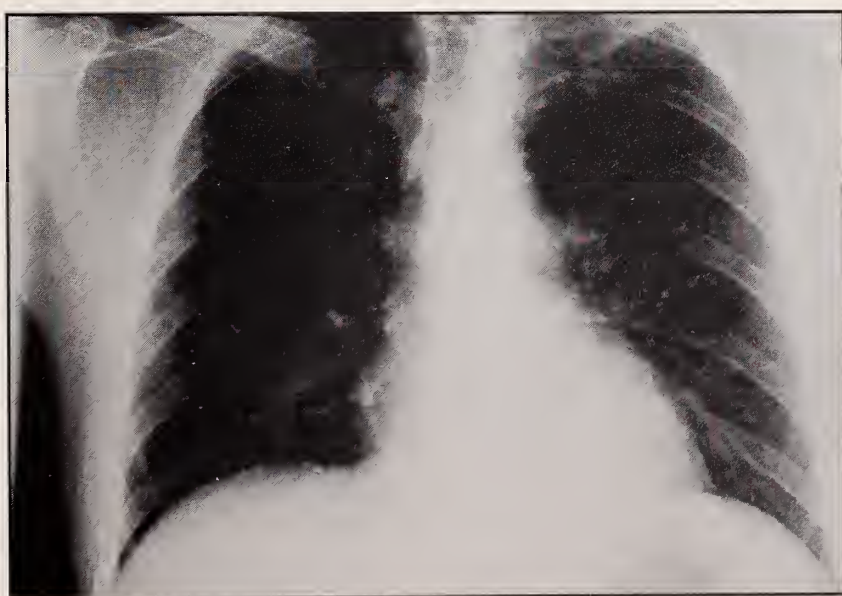


Figure 3 — *Mycobacterium avium-intracellulare*. Radiographically, indistinguishable from *Pneumocystis*.



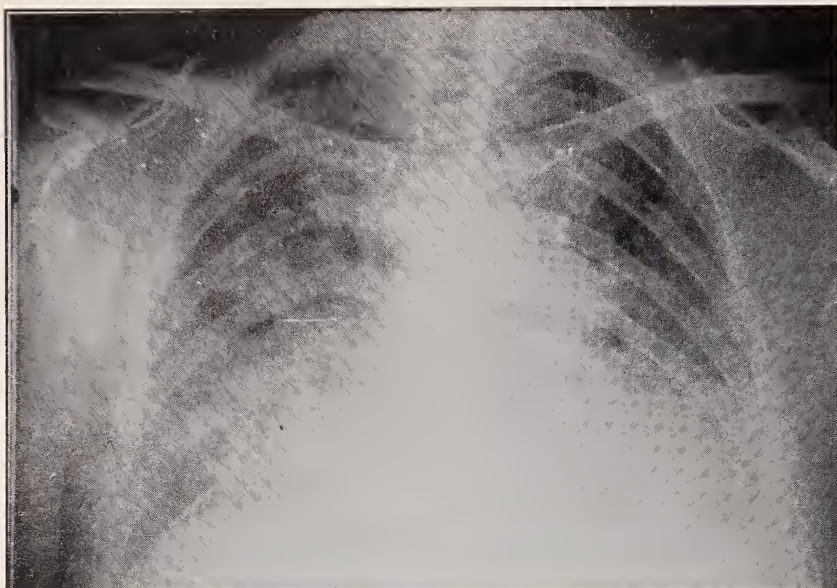


Figure 4 — Kaposi's sarcoma. Extensive bilateral infiltrates and pleural effusion.

lymphadenopathy or cutaneous involvement prior to pulmonary KS. Rarely, lung involvement precedes cutaneous or visceral disease.

In the pre-AIDS era, the classic radiographic findings included hilar and mediastinal adenopathy, pleural effusion, and bilateral nodular infiltrates. AIDS patients may develop similar radiographic features; however, a diffuse infiltrate like PCP is not uncommon.<sup>10</sup> Other descriptions include diffuse patchy nodular infiltrates and diffuse linear infiltrates. Pleural effusion is present 30% of the time, either unilaterally or bilaterally. In many instances, KS coexists with infection, and radiographic differentiation is difficult (Figure 4). Bronchoscopy has a low diagnostic yield, and the antemortem diagnosis often requires open lung biopsy.

While Kaposi's sarcoma is the most common malignancy accounting for 85% of the cancer in homosexual men,<sup>11</sup> lymphoma is the next most prevalent. This is usually non-Hodgkin's, high grade, B cell type and is found in 4-10% of AIDS patients. At the time of diagnosis, the majority of patients have extranodal disease primarily in the CNS but also including the GI tract and bone marrow. Thoracic

involvement is unusual. Low-grade B cell lymphoma and Hodgkin's disease are not considered a part of the AIDS spectrum. Mediastinal adenopathy, pleural effusion, and nonspecific infiltrates have all been reported in AIDS-related lymphoma.

### Summary

The AIDS epidemic continues to spread in Georgia.<sup>2</sup> Almost every medical specialty is affected in some manner by the increased number of patients being diagnosed and treated with AIDS or the AIDS-related complex. Radiology has a pivotal role in documenting various opportunistic complications so that further testing and therapy may be instituted.

Because of the large number of AIDS patients that develop thoracic disease, we have reviewed many of the potential pulmonary complications and their radiographic findings. Certain patterns of disease may suggest etiologies, though admittedly the chest radiograph is nonspecific. Diagnosis must be confirmed with sputum culture, bronchial lavage, and biopsy or open lung biopsy.

There are key features that should be kept in mind. *P. carinii*, the most common pathogen, and several other opportunistic agents usually present with a fine bilateral interstitial or ground glass appearance. The presence of mediastinal adenopathy and/or pleural effusion suggests an etiology other than PCP. These findings are indicative of mycobacterial infection, KS, or lymphoma. PCP can present as a focal pulmonary consolidation, but this is unusual, and bacterial pneumonia must be considered. Finally, a small percentage of persons will present with a normal chest x-ray despite the presence of pulmonary infection or neoplasm. In those cases gallium lung scanning can help identify the affected individuals.

### Acknowledgements

We thank Judi Hoffman and Gretta Miller for their assistance in manuscript preparation.

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# Change the Tort System: Expose It To Patients

Murray Freedman, M.D.

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**The true merits of a case need to be determined through an honest and impartial evaluation by competent experts prior to going through the expensive adjudication process.**

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**I** AM NOT AN EXPERT on malpractice. I am an ex-obstetrician/now gynecologist, who, like many of my colleagues, is a casualty of the current tort law system. Like just about everyone else in America, I hope to achieve financial security at some point in life, and I have no desire to become a pauper because of an isolated, single, honest mistake. One errant decision — even one made sincerely, intelligently, and in good faith — can lead to total ruin. Specifically speaking, even though the obstetrician made no error in the care of the patient, the delivery of one imperfect baby could lead to a suit causing financial disaster. I refuse to continue to expose my family to such liability.

That is precisely why I stopped practicing obstetrics. The liability is simply too great. Risk now exceeds the pleasure, and monetary gain. The key issue is not excessive premiums, even though \$70,000 is exorbitant. Undeniably, it is the stress and the liability. Even if I were to die tomorrow, this vulnerability and incessant anxiety would be borne by my family and/or my estate for

another 18 years under Georgia law. Would a federal judge expose his or her family to such liability for every single decision? No matter how many lives are saved or miracles worked, your entire welfare can be threatened by any individual performance. Can you bat 1,000 every year, my friend?

I have no animosity toward lawyers, but I cannot condone what some of them are doing. I believe some are preying not only on the

medical profession but also on society as a whole. I firmly believe it is time we physicians responded to what is happening in medicine, not by attacking the legal profession, but by helping to reform the tort law system as it pertains to our profession. It begs revision, and patients will lead the way — once they are informed. First, my fellow physicians, you must stand up and be counted.

There is truly a liability crisis in our society today. Obstetrics is involved more frequently than any other specialty because of some enormous settlements awarded by sympathetic juries for the neurologically impaired infant. Since 2% of all pregnancies culminate in the delivery of an abnormal infant, the frequency of suits quickly escalates in a society rightfully anxious to compensate its compromised offspring. Society's obligation is genuine, and the physician is dutifully *accountable* . . . but not necessarily *responsible*. The obstetrician welcomes accountability — not responsibility — for nature's mistakes. The physician is responsible

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only when the "standard of care" is not provided.

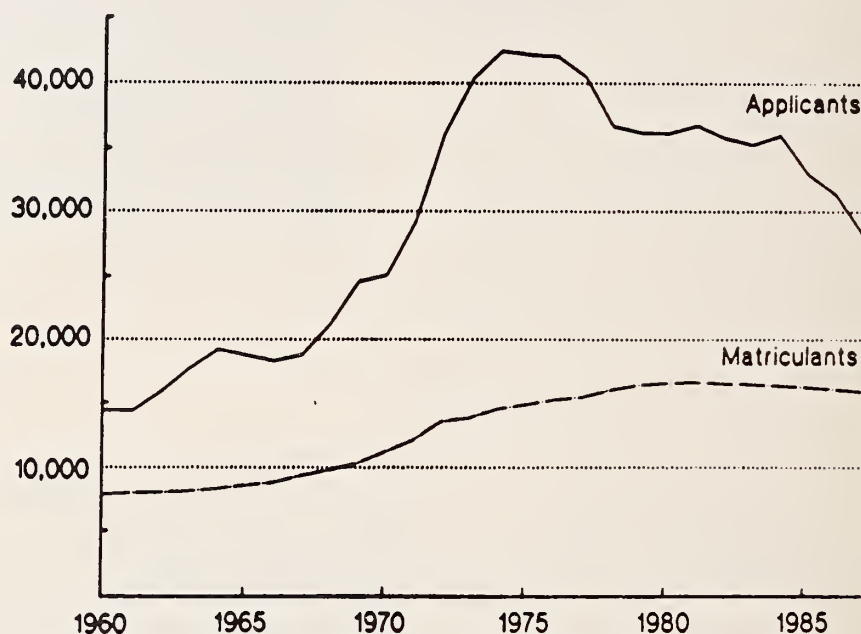
**A**n expanded level of liability is not limited to obstetrics. While 73% of obstetricians have been sued once and 40% have been sued three or more times, six out of every 10 doctors have been sued.<sup>1</sup> As an obstetrician, you can expect eight suits during a 35-year career. Since it usually requires 3-5 years to settle a claim, you are always either preparing, fighting, or recovering from the ravages of a suit. Any doctor can be sued by any patient at any time for anything he or she did or did not do!

Anyone who has ever been served a summons can attest to the cataclysmic ramifications of such an accusation — irrespective of the suit's frivolity. Physicians in America are being sued inordinately. We have the best medical care system in the world, yet we have three times the number of suits of any other free country.<sup>2</sup> There are incompetent doctors, but not such an inordinate number as indicated by the plethora of suits.

There is more to the story. A litigious society presents a problem for medicine. The most fundamental issue, however, is for society itself: a decline in the quality of health care. This is a message we need to get to our patients. As a society, they do not see the ultimate effect: medicine is losing (and no longer attracting) many of its best doctors. Until our patients perceive this and help us reform the tort law system as it applies to medicine, we are going to experience a steady decline in the quality of health care.

To be convinced of the deteriorating quality of health care, you need only look at what is happening in medical school applications. Ten years ago, there were more than three applicants per position; in 1987 there were only 1.7 applicants per position.<sup>3</sup> If this trend continues, there will soon be only 1 applicant per position. When almost anyone who finishes college can attend medical school, the quality of health care will suffer accordingly.

## Number of Medical School Applicants and Matriculants 1960 to 1987



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Medical and paramedical people are no longer encouraging "their own" to pursue medical careers. At several recent medical meetings, 80-90% of participants queried stated they no longer felt medical careers were attractive. My father is a doctor, as are my uncle, my wife, and my brother. I now find it rather difficult to encourage my son to pursue a career in medicine. The classic role model who previously encouraged the outstanding, aspiring students is now discouraging this stellar group of young people.

**T**he public needs to be made aware of this declining appeal of medical careers. Our very own personal health care may soon be compromised by this process. What will future physicians be like? We have an obligation to perpetuate the present quality of medical care available in this country.

Three factors contribute to this increasing disenchantment with medicine:

- 1) an escalating bureaucracy and federal economic constraints
- 2) the AIDS epidemic
- 3) an ever-expanding malpractice liability.

Of the three, the one most amenable to immediate alteration is the liability crisis. If we enlist the voting power of our patients, we can solve this problem. Stand up. . . . It is certainly more a challenge for society as a whole than for physicians, but we must educate society. Our job is education — not fighting the Trial Lawyers Association. Doctors can walk away from medicine, but disease and illness will always remain a problem for society. This potential inaccessibility of good, quality health care providers is a reality pa-



tients need only be made aware of — then they will become involved. Patients and physicians have always been compatible advocates. It is only with the advent of expanded liability that this traditional role has been made into an adversarial relationship.

**A**mong physicians, obstetricians are the most susceptible to injustice under the present tort law system. Anything less than a perfect infant elicits immediate anxiety regarding legal repercussions — irrespective of the quality of care provided! The vast majority of pregnancies do result in healthy babies, but this jubilant attitude should be couched with the caveat that some of these pregnancies will result in the delivery of an abnormal child.

While many physicians complain bitterly about the economics of the liability crisis, this offensive monetary burden is merely a secondary factor. Unrelenting, incessant anxiety remains the key irritant. Since 40% of obstetricians have been sued three or more times, who will elect to deliver the babies if the tort system continues unabated? The stress simply becomes intolerable.

Florida happens to be the worst area of the country for malpractice litigation, but Georgia ranks fourth. Sixty-seven Georgia counties no longer have a practicing obstetrician. Over 40% of obstetricians in Georgia no longer deliver babies, and two-thirds of those stopping OB practice are under 55 years of age. It is the younger doctors who are getting out of obstetrics, and if it were not for a tail coverage rapidly approaching \$100,000, more obstetricians might elect to terminate their obstetric services.

Part of the increase in tort cases can be attributed to the easy access to suit. It only requires an aggressive attorney, an unhappy patient, and \$65. An expert witness is oftentimes not even required in the initial stages of litigation. It has been estimated that 10% of all patients in any given practice are disgruntled about something.<sup>1</sup> In a population of 260 million people, there will always be many unhappy patients. There is certainly no paucity

of eager lawyers to encourage them to become malpractice plaintiffs.

**I**ronically, the tort law system is particularly good in principle. It provides a rational, civilized method to redress wrongs. Without it, angry patients would be stalking physicians in the streets with clubs in hand. Tort law, the concept, is less the problem than the abuse to which it is exposed. Consider New Jersey: there were over 75,000 tort cases submitted in 1985 alone. How can any system handle that? Though in principle the system is good, its current implementation is absurd.

The obvious enticement for a lawyer is the contingency fee. This is usually about 40% of the settlement; even 50% on occasion. This is entirely irrespective of how little time a case may require. In a recent local suit with a big six-figure settlement, the lawyers took \$450,000 in cash at settlement and the plaintiff received \$4,000 per month (\$48,000 per year) for 10 years in an annuity contract. In terms of purchasing power, the lawyers received far more compensation than the plaintiff. This raises a real question about integrity.

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**Over 40% of obstetricians in Georgia no longer deliver babies, and two-thirds of those stopping OB practice are under 55 years of age.**

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This is the kind of situation that needs exposure. Such examples of greed will make the public aware of plaintiff abuse by some attorneys. Large contingency fees are avaricious to say the least. California has already put a limit on attorneys' excessive contingency fees. If we compensated police officers via a contingency fee (i.e., 40% of the citations issued), there would soon

be no one but police and slow overcrowded buses on the highways. Just as contingency fees for police officers would create chaos for drivers, it has done so for the medical profession. Attorneys should work on a fee-for-service basis just like any other self-respecting professional.

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**While 73% of obstetricians have been sued once and 40% have been sued three or more times, six out of every 10 doctors have been sued.**

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There are numerous examples to show that medicine and law are immisible:

- Different therapies may be equally effective — only large studies over a period of time will prove which is better. In a court of law, a decision is made *today* as to one therapy being *right*, the other being *wrong*.
- Caring-sharing relationships lead to better medical care — lawyers thrive on creating an adversarial relationship to initiate more suits.
- Medicine favors equitable reparation for injury if negligence is involved (i.e., the purpose of insurance). Law favors awards based upon emotion determined by untrained jurors whose only medical knowledge is obtained from biased, paid advocates. Society needs a mechanism to determine reasonable reparation for injury when negligence causes it, not a lottery system of windfall for some and nothing for others.

**A** logical solution would be to remove health related injury from the traditional tort law system. It would be better served in a new system built from the framework of workman's (or more properly "worker's") compensation. The

AMA has proposed this, but better yet, patients will probably demand it when all the facts are known. Fair compensation for injury, if allocated by professional adjusters, would eliminate the need for caps on pain and suffering. These panels of adjusters could be comprised of attorneys, physicians, ministers,

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**The public needs to be made aware of this declining appeal of medical careers. Our very own personal health care may soon be compromised by this process.**

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and knowledgeable business leaders. Unconscionable contingency fees and the agonizing delays in the normal adjudication process might thus be eliminated, and such a board could dispense with cases very expeditiously and economically. Patients, physicians, society — even lawyers — would be winners.

In any event, the true merits of a case need to be determined through an honest and impartial evaluation by competent experts prior to going through the expensive adjudication process. Currently, only 25-28% of indemnity dollars ultimately go to

the plaintiff! Even the federal bureaucracy operates under a system wherein only  $\frac{1}{3}$  of the money in a program is retained for administration and  $\frac{2}{3}$  goes to the program's recipients. The present tort law system pays the injured party only about  $\frac{1}{4}$  of all of the money involved.

Fellow colleagues, stand up and be counted! Under current tort law, the quality of health care in this country is at stake. This is an issue to which the public will respond. The scenario goes something like this: "Doctor, you drive a Mercedes, you wear fine clothes, and your children go to expensive private schools while you live in expensive homes. I really don't care how much you pay for malpractice insurance. . . . What, you mean my daughter may have difficulty finding a good obstetrician to take care of her? Now, I *am* interested in that!"

We must enlist our ally, the patient. Patients know and trust *their doctor*. Numerous polls reveal that patients may have great reservations about medicine, but when asked about their own personal doctor, the physician fares reasonably well. Public opinion of doctor's esteem and high ethical standards range in the high 50% range whereas lawyers are in the 20% range.<sup>4,5</sup>

Let us not waste all of our efforts trying to legislate change. To be counted, let us educate our patients. All that is needed is to inform them. We can all do this, but it must be done individually by *you* with *your* patients.

Is there other help available? Yes. Remember: as private medicine goes, so goes the pharmaceutical industry. If there is nationalization of health care, there will probably be only one generic for each category of brand-name drug. Large pharmaceutical companies have billions of dollars in assets to protect; product liability remains a tremendous concern for all such companies. Expanded liability is as onerous to them as it is to medicine. Using their resources and our knowledge (and an alliance with our patients), changes can be made. Lawyers, abundant as they are, still comprise less than 1% of the population. Out patients are our advocates, not our adversaries. There is strength in these numbers.

Stand up and be counted. We owe medicine a debt of gratitude. This profession is still a most rewarding endeavor, and it must be preserved. We owe it to our families and to society. Our greatest enemy is apathy, not the legal system. Pogo is appropo: "We have met the enemy and they is *us*." Let us educate our patients; they will demand the necessary change.

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# Health Care History and Utilization for Atlantans Who Died Homeless

Randy Hanzlick, M.D., John Lazarchick, M.D.

## Introduction

**T**O DATE, there is only one published study of mortality among homeless persons, and that study is limited.<sup>1</sup> There are no studies in the literature regarding prior health care utilization by persons who died homeless, although studies of health problems among living homeless persons do exist.<sup>2-10</sup> This report is a limited pilot study of health care utilization by homeless persons who died in Atlanta, Georgia, during the first six months of 1987, directed at providing preliminary data that may have practical application to public health care strategies, death investigation, and further studies of mortality in the homeless.

## Abstract

**A LIMITED STUDY of 18 deaths among homeless persons in Atlanta, Georgia, has shown that about two-thirds had utilized public health care facilities prior to their death, often over a period of many years. Utilization of two available, specific clinics for the homeless could not be demonstrated. The county hospital and alcoholism treatment center accounted for all documented episodes of health care. Formal, medical documentation of significant alcohol-related morbidity was shown in 50% of those who died homeless. Other common medical problems included seizure disorders, hypertension, pneumonia, chronic pulmonary disease, and non-lethal trauma. These data may be used practically during medico-legal death investigation and by public health agencies when planning policy and procedure relevant to the homeless population. Paucity of data concerning mortality in the homeless should prompt additional, region-specific studies to determine risk factors in areas where homelessness is manifest.**

## Methods

Deaths of homeless persons who died in Atlanta-Fulton County, Georgia, in the first 6 months of 1987 were computer catalogued as they were reported to the Fulton County Medical Examiner. Fulton County has an estimated 1987 population of 650,500 persons, of which 4,000 to 7,000 are reportedly homeless.<sup>1</sup> Specific demographics of the living homeless population are unreported and unknown. Although homelessness *per*

se does not require a death to be reported to the medical examiner, many such deaths are sudden, suspicious, or unattended by a physician which results in an investigation by the medical examiner. Medical examiner data should

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therefore be fairly sensitive with regard to detection of mortality in the homeless. However, an unknown, but probably small number of deaths among homeless persons who died in hospitals would not require medico-legal investigation and are not included in this report.

An attempt was made to locate medical records and document health care utilization at several local health care facilities. These in-

its, and if available, the reason for admission or consultation.

Results

Eighteen deaths occurred during the study period, quite consistent with previous Atlanta homeless mortality rate estimates of 5.7 to 10 per 1000 homeless persons.<sup>1</sup>

Table 1 summarizes demographic data, cause of death, blood alcohol, and health care utilization

median age was 56 years, and 61% were caused by, related to, or involved alcohol.

Alcohol Treatment Center Data

Eight of the 18 individuals had previously been inpatients at the Fulton County Alcoholism Treatment Center, and all were males. The interval between the first admission and most recent admission (rounded to the nearest whole

TABLE 1 — Age, Race, Sex, Cause of Death, Blood Alcohol Concentration (BAC) At Time of Death, and First and Last Visit Dates For Persons Seen at Fulton County Alcoholism Treatment Center (FCAT) and Grady Memorial Hospital (GMH).

AGE	R	S	CAUSE OF DEATH	BAC	FCAT	GMH Visits	
56	W	M	Chronic Alcohol Abuse	Neg	10/73-1/86	3/74-1/85	6
51	B	M	Homicidal Gunshot	359			
76	B	M	Building Fire	Neg			
38	B	M	Alcohol Poisoning	570	8/81-6/86	1/86	1
25	B	M	Hypothermia	Neg			
40	B	M	Chronic Lung Disease	NT		12/86-1/87	3
49	W	M	Chronic Alcohol Abuse	328	6/74-8/86		
64	W	M	Clothing Fire	23	3/77-12/86	7/81-11/87	3
58	B	M	Heart Disease	Neg			
57	W	F	Heart Disease	NT		7/83-4/87	4
50	W	M	Heart Disease	Neg	4/78-4/80		
47	B	M	Homicidal Stab Wound	242	2/83-10/83		
54	W	M	Heart Disease	Neg		8/85-3/87	4
63	B	M	Building Fire	357	12/75-10/85	6/85-1/86	2
57	B	M	Hypertension/Alcoholism	NT			
58	W	M	Chronic Alcohol Abuse	Neg	Record Lost		
60	W	M	Chronic Alcohol Abuse	Neg			
30	B	M	Homicidal Gunshot	194			

Number at far right indicates number of visits/admissions to Grady Hospital. Data is for homeless persons who died in Atlanta, Georgia during the first six months of 1987.

stitutions were located in the central city close to areas typically inhabited or frequented by homeless persons. Health care histories were obtained from Grady Memorial Hospital (a large, county hospital), the Fulton County Alcoholism Treatment Center, the Health Care Clinic for the Homeless (operated by the Georgia Nursing Foundation, Inc.), and the Medical Association of Atlanta's Clinic for the Homeless. Grady Hospital and the Alcohol Treatment Center have been open for decades, while the latter two institutions have been operating since May of 1984 and October of 1986, respectively. The main study objective was to determine if homeless persons who died had used any of these facilities. Secondary objectives included determination of the dates of any vis-

data for each case. Except for the health care utilization data, the data were similar to a previously published series of 40 deaths among

About two-thirds of the homeless persons had used public health care facilities prior to their deaths, often over a period of many years.

Atlanta's homeless population.<sup>1</sup> Seventeen of 18 deaths occurred in males, 10 of 18 were black (proportionate to black representation in the county-wide population), the

number of years) ranged from 1 to 12 years, with a mean of 7 years and a median of 9 years. Five of the eight individuals were white males. Four of the eight persons treated had been seen within one year of their death.

Medical Association of Atlanta Clinic for the Homeless

Utilization of this facility could not be documented by an examination of in-house records.

Georgia Nurses' Health Care Clinic

A search of records at this facility also failed to document utilization by any of the decedents.

Grady Memorial Hospital

Seven of the 18 persons had been previously seen or admitted at Grady Memorial Hospital. The number of hospital visits ranged from one to



six, with a mean of 3 and a median of 3. There were seven outpatient visits divided between three individuals and 16 hospitalizations divided among six. Two people had outpatient visitations and in-patient admissions. Six of the seven persons seen at this institution had multiple visits. For those with multiple visits, the time over which the visits occurred were 2 months, 6 months, 2 years, 4 years, 6 years, and 11 years. Four of the seven homeless persons seen at Grady Hospital had also been inpatients at the Fulton County Alcoholism Treatment Center.

Medical problem lists for the seven persons seen at Grady Hospital are shown in Table 2. Numerous conditions were cited in the problem/complaint lists: chronic ethanol abuse, seizure disorders, hypertension, pneumonia, chronic pulmonary disease, and non-lethal trauma were the most common problems identified.

#### Overall Utilization

It could be documented that 11 of 18 persons who died homeless had, on prior occasions, utilized one or more health care facilities. Utilization was limited to the alcoholism treatment center and the county hospital. Three people had been evaluated at the county hospital only, four at the alcoholism treatment center only, and four at both facilities. Between the county hospital and the alcoholism treatment center, it could be documented that nine of the 18 decedents had been previously evaluated for chronic ethanolism.

#### Discussion

This pilot study is admittedly small in its size and scope, but similar data is absent from the medical literature. Despite the limited data, some evidence exists to support some preliminary opinions which deserve further study, both locally and in other jurisdictions.

The questionable sensitivity of medical examiner data pertaining to surveillance of homeless mortality has been previously raised.<sup>1</sup> Retrospective examination of the medical histories of those who died homeless showed a distribution of

**TABLE 2 — Pre-death Medical Problems of Seven Homeless Persons Who Died At Later Times.**

Chronic Alcohol Abuse	5
Seizure Disorder	4
Non-lethal trauma	4
Hypertension	3
Pneumonia	3
Chronic Lung Disease	3
Neuropathy	2
Cardiovascular Disease	2
Fever	1
Anemia	1
CNS Hemorrhage	1
Upper GI Hemorrhage	1
Hypothermia	1
Diabetes	1
Urinary Tract Infection	1
Tuberculosis	1
Syncope	1
Pharyngitis	1
Viral Syndrome	1
Bowel Obstruction	1

Number at right represents number of individuals who had each particular problem identified in a hospital chart at Grady Memorial Hospital.

medical problems which was similar to causes of homeless mortality as determined by medical examiners relying on less complete medical histories.<sup>1</sup> In other words, if some of these individuals had died in the hospital and their deaths were not investigated by the medical examiner, their causes of death would probably be similar to those ultimately appearing in a medical examiner series. Medical examiner data might therefore underestimate the number of deaths among homeless persons, but the relative causes of death would be similar and useful in surveillance of homeless mortality.

From the death investigation standpoint, the data indicate that the medical examiner had approximately a 2 to 1 chance of finding a documented medical history for a person who died homeless if county hospital and alcoholism treatment centers were contacted. If a homeless person dies unidentified, particularly if the decedent is a white male, the alcoholism treatment center would be a good place to show facial photographs in an attempt to establish tentative identity. Otherwise, the county hospital and alcoholism treatment center appear to be good sources to con-

tact for potentially useful medical history information.

The inability to document utilization of health care clinics for the homeless was somewhat surprising. Both of the clinics in this study are adjacent to soup lines, food kitchens, and other services for the homeless, such as temporary labor centers, which together serve nearly 1000 individuals per day. Health care clinics for the homeless are certainly utilized; the Georgia Nurses' Clinic for the Homeless serves 20 to 30 individuals per day. However, we simply could not document that homeless persons who died had used the clinics. Possible explanations include the use of aliases, less formal identification and record keeping than that used in hospitals, and among the group of those who died, the presence of relatively serious medical problems which require more than outpatient care.

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**Data for Atlanta thus far indicate that most deaths among homeless persons are due directly to the acute or chronic effects of alcohol (including withdrawal) or indirectly to accidents involving persons who are intoxicated with alcohol.**

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Our previous study of Atlanta's homeless mortality indicated a strong association between death and alcohol usage.<sup>1</sup> The data in this study support that finding by documenting a formal medical history of alcohol abuse in 50% of those who died homeless. Further, the medical histories of those with alcohol-related problems had, in general, been documented over a

period of many years. All but one of the decedents who had been seen at the alcoholism treatment center died of alcohol-related causes (4 cases) or were intoxicated with alcohol at the time of an external

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**These data may be used practically during medico-legal death investigation and by public health agencies when planning policy and procedure relevant to the homeless population.**

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cause which lead to death (3 cases). When one considers the additional alcohol-related deaths that occur in individuals without formal histories of alcohol abuse, the effects of alcohol on homeless mortality in Atlanta cannot be ignored.

From the public health perspective of homeless mortality, preliminary data from this and our previous study indicate that policy and procedure in Atlanta should be focused on alcohol countermeasures. Data for Atlanta thus far indicate that most deaths among

homeless persons are due directly to the acute or chronic effects of alcohol (including withdrawal), or indirectly to accidents involving persons who are intoxicated with alcohol. However, mortality in the homeless must be studied regionally in order to determine what interventions will be most effective in a given area where homelessness is manifest.

### **Conclusions**

A limited study of 18 deaths among homeless persons in Atlanta, has shown that about two-thirds had used public health care facilities prior to their deaths, often over a period of many years. Utilization of two available, specific clinics for the homeless could not be demonstrated; the county hospital and alcoholism treatment center accounted for all documented episodes of health care. Formal, medical documentation of significant alcohol related morbidity was shown in 50% of those who died homeless. Other common medical problems included seizure disorders, hypertension, pneumonia, chronic pulmonary disease, and non-lethal trauma. These data may be used practically during medico-legal death investigation and by public health agencies when planning policy and procedure relevant to the homeless population. Paucity of data concerning mortality in

the homeless should prompt additional, region-specific studies to determine risk factors in areas where homelessness is manifest.

### **Acknowledgements**

The authors wish to thank the following individuals for their cooperation in this project: Carol Jean Delcher and Jean Alley, Georgia Nursing Foundation's Health Care Clinic for the Homeless; Dan Danner, Medical Association of Atlanta's Clinic for the Homeless; Rebecca Burkhart, Fulton County Alcoholism Treatment Center.

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# "Just Push Away From the Table!"

J.T. Cooper, M.D., M.P.H.

**O**BESITY IS PROBABLY ONE of the greatest health problems facing Americans today. Every community, no matter how small, has its share of overweight citizens. The average primary care physician has the difficult task of helping a substantial portion of his or her patients lose unwanted and sometimes dangerous pounds, both to help cut the risk factors inherent in obesity and to meet the desires of each patient to look slimmer and feel more self-esteem.

Dr. William Headley pointed out the dangers of morbid obesity in his two part article in the February and March issues of the *MAG Journal*. Even moderately severe obesity of 120% over ideal body weight can carry its own risk. The man with an extra 40 pounds of weight and the woman with an extra 25 pounds are both in greater danger of dying at an earlier age than their normal weight counterparts.

It should be, therefore, a top priority in any doctor-patient relationship to assist the patient in getting rid of these unwanted pounds.

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**Your success or failure as a treating physician is often determined during the first encounter with an overweight patient. The nonverbal communication is often stronger than the actual words spoken by you.**

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The success rate for obesity treatment is dismal, both for short-term and long-term results. Part of this problem is a result of the sometimes justified, pessimistic attitude of the patient, and part is related to the attitudes of society in general, and of physicians in particular to the overweight patient.

The belief held by a substantial number of physicians is that obesity

is a self-induced condition that could be cured promptly if only the patient would exercise a little self-control and "push away from the table" a little more. Since alcoholism has been relatively destigmatized, obesity remains the only disease that suggests character weakness, immorality, depravity, and a total unwillingness to change and improve oneself.

This doesn't mean that this type of physician doesn't care what happens to the overweight patient. It just means he or she may feel that this type of patient has caused his or her own problem and should also be able to remedy it alone. Difficult obese patients with poor success records are somehow threatening to all of us at one time or another. We long for the "magic bullet" to cure them, much as we can cure an infection with an antibiotic. We have no cure for obesity yet. Therefore many of us have a safe way of dealing with the overweight persons who dare enter our office — we reject them in subtle or even direct ways.

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"All you have to do is exercise more by pushing away from the table," is a favorite saying of many. It is usually said with a huge laugh at the obese patient's expense. "Take this diet sheet, and don't come back until you have lost your weight." Don't bother me with your weight problems. All you need to do is eat less, and you'll lose weight. I need to devote my time to treating sick people is the implied message.

Even when the approach is less heavy-handed, the subtle rejection is there. It is the rejection we sometimes feel ourselves showing toward "incurable," patients such as terminal cancer patients, the hopelessly ill, and all those others who somehow challenge our feelings of omnipotence by daring not to get well. At worse, we ridicule the obese openly, and at best we treat them with benign neglect and patronization. No wonder that our success rate is so poor!

**Y**our success or failure as a treating physician is often determined during the first encounter with an overweight patient. The nonverbal communication is often stronger than the actual words spoken by you. An unconscious shrug of your shoulders, a smile that is taken as a smirk, a look of disbelief at what the patient claims to have eaten since last seen, or any of a dozen other gestures and expressions can turn the patient off. This could be in spite of your genuine desire to help the patient.

The first thing to understand about someone with a chronic obesity problem is that he or she is used to failure and rejection. You may be the latest in a long line of doctors who have all failed to be successful, for one reason or another, in the management of this person's dilemma. If your efforts are successful, you will be the last and most successful therapist that he or she will ever need.

It is no wonder that the doctor who is successful in treating overweight patients soon has a crowded waiting room. Word soon gets out that this doctor, while not promising miracles, at least promises tolerance, understanding of the prob-

lem, and a sensible approach that will have a better than even chance of success. This doctor does more than give a diet sheet, a month's supply of anorectic agents, and rather vague and patronizing instructions to the obese patient before whisking him or her out the door.

We often forget that inside the skin of every overweight person is a human being. Often one with great anger, frustration, fear of rejection, depression, dissatisfaction, humiliation, and feelings of not being loved bottled up inside. Even a little bit of kindness and understanding from a physician can work wonders. When even this small morsel of help and hope is not forthcoming from us, is it any wonder that an obese person will submit to almost any treatment, including surgery, and will risk his or her life in sometimes dangerous semi-starvation pseudoscientific diets if there is even a hope that the hated and dreaded extra fat mass will be shed?

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### **Providing good obesity treatment is just another part of practicing good medicine. It doesn't require encyclopedic knowledge about dietetics.**

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**I** think all of us in primary care medicine must rethink our roles in treating our patients with an obesity problem. We can't all be experts in obesity treatment, but we can establish some sort of humane routine of therapy, or we can refer to someone in private practice, or to some local hospital-based program, where the proper type of multidisciplinary care can be given.

Since the patient's primary care physician is the most knowledgeable about him or her, this is the place to start. Bariatrics, or the medical management of obesity,

can be practiced by family practitioners, internists, pediatricians, and gynecologists. Providing good obesity treatment is just another part of practicing good medicine. It doesn't require encyclopedic knowledge about dietetics. You can always work with your local registered dietician if you don't have this knowledge yourself. Your medical work up and follow up aren't that different either. You can even turn part of the psychologic management over to a psychologist colleague. The basic requirement is that you remain the "captain of the ship" and control the overall management of your patient.

By retaining the general control of your patients' care, you fulfill the basic responsibility for protecting their welfare and health, the responsibility that your patients have honored you with by trusting you to be their doctor.

**T**here are courses given every year on the medical and surgical management of obesity. They include ones given by Harvard Medical School and the American Society of Bariatric Surgery. The American Society of Bariatric Physicians, based in Englewood, Colorado, gives at least two regional basic courses and one annual general meeting and course every year. For the average non-surgeon, the ASBP courses are a good starting point. There are also a wealth of video and audio tapes on obesity available from the AMA and the ASBP. In addition, certain commercially-produced tapes suitable for the primary care physician's continuing educational needs are available.

With all these educational opportunities available, and with the great need for our help that obese patients have, doesn't it make sense for each of us to stop rejecting them?

Try and follow what I call my Seven Commandments for dealing with overweight patients.

#### **The Seven Commandments**

**1) Thou Shalt Not Be Fat Thyself.** For many of us, the definition of an obese patient is anyone heavier than we are ourselves. Be a visual ex-



ample to your patients. It is as ridiculous for a fat doctor to tell a patient to lose weight, as it is for a smoking doctor to tell someone to quit smoking.

2) **Thou Shalt Not Reject Thy Responsibility For Thy Patient.** Even though Weight Watchers is a reputable group, and even though you may tell people to go to them, don't let that be the end of your responsibility. Be sure and follow up on each patient with advice and encouragement.

3) **Thou Shalt Not Ridicule Thy Obese Patient.** Purge the "pushing away" phrases out of your vocabulary. Don't even *think* bad thoughts about those who look to you for help.

4) **Thou Shalt Remember That Obesity Is A Killer.** Take obesity as seriously as you do cancer. It probably kills a lot more people than

malignancies do — through heart disease, strokes, hypertension, and diabetes.

5) **Thou Shalt Look Through That Layer Of Fat And See The Inner Person Who Is Crying Out For Thy Help.** The quiet desperation underlying the jolly exterior of a lot of your obese patients will only be exposed if you look for it and seek to remedy it by using your healing skills as they were meant to be used.

6) **Thou Shalt Keep Up With Thy Postgraduate Studies.** Try and spend at least 10-15 hours a year in keeping up with bariatric medicine and surgery. Most of the courses mentioned above carry full CME credits from the AMA and the AAFP. If you don't know how to contact these people, call me and I will put you in touch with them. Since obesity is such a dangerous condition, doesn't it make sense to devote at least this much time every year to keeping up with its management.

7) **Thou Shalt Teach Thy Patients Good Health And Nutrition Habits.** The Surgeon General's Report on Nutrition and Health is a good source for recommendations about cutting down on health problems through good nutrition practices. It is available for less than \$3 from any Government Printing Office location, including the one in Atlanta.

**I**n closing, as one who used to weigh 240 pounds and went through the aggravation of being fat over 22 years ago, be a little more patient and kind to the next overweight patient who seeks your help. Look inside your own mind and try to purge yourself of negative feelings about this person who is looking to you for encouragement, knowledge, guidance, understanding, and compassion. You are capable of providing all of these, so why not try and be an even better doctor today than you were yesterday? Your new results with this type of patient may amaze you.

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**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

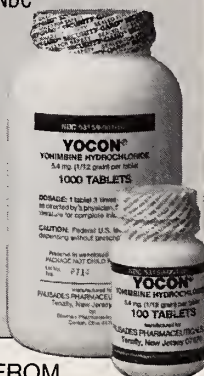
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

**Pregnancy:** Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

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#### OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

#### DOSAGE AND ADMINISTRATION

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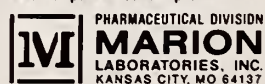
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#### Reference:

1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987;9(4):395-399.

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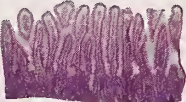
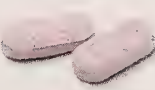
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# Mental Illness, Substance Abuse, and Criminal Behavior

Ilhan M. Ermutlu, M.D., Jimmy L. Canady, B.S.

## Introduction

**T**HE LITERATURE on the relationship between criminal behavior and mental disorders, including substance abuse, do not always agree on the comparative arrest rates among the mentally disordered and the general population. Reports prior to the 1960s indicated lower rates for the mentally disordered.<sup>1-3</sup> However, publications in the 1960s or thereafter showed higher arrest rates for ex-patients.<sup>4,6</sup>

Discovery of phenothiazines in the early 1950s facilitated the discharge of thousands of patients from state hospitals. The phenomenon of deinstitutionalization in the late 1960s and early 1970s resulted in the release of large numbers of severely and chronically mentally disabled to the communities. Since then, the number of mental disor-

## Abstract

**D**URING A 6-month period, 423 inmates were referred to the mental health services in an urban county jail. The data gathered indicate significant psychopathology and recidivism in the group. Mentally disordered inmates reported a rather high rate of positive family history of psychopathology. The study points out the need for extensive mental services in city and urban county jails.

dered in prisons or jails has steadily increased.

Zitrin and his colleagues published a paper in 1976 regarding crime and violence among mental patients.<sup>7</sup> They found higher arrest rates in a group of 867 patients than the rates for the general population living in the same area. Spodak reported in 1984 that

56% of discharged not-guilty-by-reasons-of-insanity patients were arrested following their release from the hospital.<sup>8</sup>

A study in Great Britain indicated that over a 4-month period, 2743 men were

placed in a city jail, of which 246 of them (9%) showed major symptoms of psychiatric illness, and 237 (8.7%) had symptoms of withdrawal from drugs and alcohol. A total of 237 men were considered psychotic, and 70% of those were schizophrenic. Prevalence of schizophrenia among men convicted of homicide (11%) and arson (30%) was higher than the expected morbidity rate of 0.1-0.4% in the general population.<sup>9</sup>

Another British study reported that in a prison setting, 78% of those with active psychosis and with previous psychiatric hospitalization had prior arrest records. For those

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TABLE 1 — Median and Average Age

Group	Median Age	Average Age
All referrals (N=423)	28	28
First offenders (N=61)	25	26
History of treatment/arrest (N=355)	29	30
History of treatment/psychosis (N=138)	29	30
Black males	28	28
White males	29	30
White females	27	30
Black females	30	30

with psychopathy, the recidivism rate was 42%.<sup>10</sup>

Most of the literature on the mentally disordered offenders primarily focuses on the prisons. Studies in city or county jails which are the entry points to the criminal justice system are scarce. This paper analyzes data concerning referrals to the mental health services in an urban county jail.

### **This paper analyzes data concerning referrals to the mental health services in an urban county jail.**

DeKalb is one of the large metropolitan Atlanta counties in Georgia. It has a population of 520,000, with a black to white ratio of 30.8% to 69.2%, respectively (DeKalb County Planning Office figures). Official capacity of the county jail is 824, but during the 6-month study period, the inmate population jumped to 900 several times, and the number of bookings at the jail was 14,633. A relatively large number of persons arrested are released after booking and never enter the jail as inmates. This report is based on data from the inmates of the jail.

The mental health services in the DeKalb County Jail are provided by a part-time psychiatrist and a full-time social worker employed by DeKalb County Board of Health. The County administration contributes a portion of the personnel cost. The social worker, whose office is located in the jail, provides clinical

and consultative services along with some case management.

### **Methodology**

This report is based on data collected on referrals to the mental health staff between September 1, 1986, and February 28, 1987, covering a 6-month period. The number of unduplicated referrals were 423. The information collected consisted of basic demographic data (age, sex, race, marital status), history of psychiatric treatment either in a hospital or on an outpatient

health and mental health issues are recorded. When there is a question of physical or mental illness as well as positive past history, the information is communicated to the infirmary or the social worker. The social worker screens the cases and, when necessary, schedules them for psychiatric evaluation and follow up.

Among other reasons for referral to the mental health staff are signs of mental or emotional disturbance as observed by the jail staff, behavior problems (aggressive or violent behavior, resistance to rules, bizarre or unusual behavior) and requests from inmates themselves. At times, various agencies in the community, particularly mental health centers, inform the staff if one of their clients is jailed.

The rate of referrals was about 3% of all bookings during the data gathering period. It is estimated that the active case load in the jail is about 10-13% of the jail population at any given time.

TABLE 2 — Age and Racial Breakdown

Age	WM	WF	BM	BF	OM	OF	IM	Total	%
Below 20	11	1	23	2	1	0	0	38	9
20-29	63	27	91	16	0	0	0	197	46.6
30-39	51	12	60	17	0	0	1	141	33.3
40-49	10	4	11	4	0	0	0	29	6.9
50-59	5	4	5	0	0	1	0	15	3.5
60-over	2	0	0	1	0	0	0	3	0.7
TOTALS	142	48	190	40	1	1	1	423	100.0

OM = Oriental male  
OF = Oriental female  
IM = Indian male  
IM = Indian male

basis, presence of psychotic symptoms at the time of arrest, other symptoms of emotional disturbance, whether or not the person was on psychotropic medication just prior to arrest, history of arrest or conviction, history of substance use, family history of mental illness and substance abuse, and the charge(s) against the inmate.

### **Reasons For Referral**

Every newly admitted inmate is reviewed by the Classification Unit at the jail and information regarding

### **Demographic Characteristics of Referrals**

As Table 1 shows, both the median and average age in the studied group was 28. First offenders were generally younger, and inmates with prior arrest or treatment record were slightly older.

Marital status: 293 inmates were single; 68 were married; 54 were divorced; seven were separated; one was widowed. A total of 56% of the inmates were less than 30 years of age; 38 were below age 20 (Table 2).



TABLE 3 — Summary of Findings

Group characteristics	WM	WF	BM	BF	OM	OF	IM	Total	%
History of prior treatment	47	20	55	10	0	1	1	134	31.6
Psychotic symptoms at arrest	17	2	31	2	0	0	0	52	12.0
On medication at arrest	25	11	24	7	0	1	0	68	16.0
History of substance abuse	119	37	139	27	0	0	1	323	76.3
Previous arrest record	121	36	162	34	0	1	1	361	85.0
Family history of MD/SA	49	19	78	13	0	0	1	160	37.8

OM = Oriental male  
OF = Oriental female  
IM = Indian male

Table 3 gives the breakdown on various characteristics on the basis of either inmates' responses or on our evaluations. Only four inmates were found to have psychotic symptoms at the time of arrest without prior history of treatment. The critical figures are the percentages of prior arrest record (85%) and history of drug or alcohol abuse (76.3%). Also, it should be noted that the rate for positive family history of mental disorder and/or substance abuse (37.8%) is much higher than the rate for general population (17%).<sup>13</sup>

ily history for MD/SA in inmates without past psychiatric treatment (N=86) was 30%. Also, 47% of white inmates in Group A reported positive family history for MD/SA. The rate for black inmates was 60%.

Table 4 gives a more detailed breakdown of data on family history for MD/SA in Group A. Of 56 inmates who had no history of psychiatric treatment or substance abuse, only 4 (7%) reported positive family history. Even if the percentages of positive family history of MD/SA are reduced due to possible inaccuracies in reporting, the

**This study shows the need for comprehensive mental health services in the metropolitan city and urban county jails where large numbers of chronically and acutely ill individuals are incarcerated.**

TABLE 4 — Positive Family History of MD/SD in Group A

WM (N=48)		WF (N=20)		BM (N=58)		WF (N=10)	
(N)	(%)	(N)	(%)	(N)	(%)	(N)	(%)
21	43.7	11	55.0	38	65.5	3	30.0

The group with a history of prior psychiatric treatment (134 inmates) along with four inmates with active psychosis but without past treatment will be the focus of this report. This group will be identified as Group A in the text. Group A (N=138) makes 32.6% of referrals in the study.

#### Positive Family History of Mental Disorder/Substance Abuse (MD/SA)

In Group A, 74 inmates (53.6%) reported family history of MD/SA among immediate or close family members. The rate for positive fam-

difference in rates is still significant. The degree of familial psychopathology in Group A is worth noting. Black males and white females reported considerably high figures.

#### Recidivism

A total of 84.7% of inmates (N=117) in Group A had previous arrest records. The rate of recidivism in the total referrals was 85%, and among inmates without history of psychiatric treatment it was 85.6%.

Among inmates with no history of psychiatric treatment or sub-

stance abuse, the prior arrest rate was 57%, but in 366 inmates with either history of treatment or substance abuse, the rate was 89.8%. Of 160 inmates with positive family history of MD/SA, 151 had previous arrest record (94%). These figures suggest that individual or familial psychopathology and substance abuse contribute significantly to recidivism.

#### Criminal Charges Leading to Arrest

Table 5 lists various charges placed against the inmates of Group A. A total of 138 inmates were charged with 201 different offenses.

TABLE 5 — Charges at Arrest For Group A

Abusive language	1	Murder	7
Aggravated assault	18	No insurance	2
Aggravated sodomy	1	Obstruction of officer	2
Armed robbery	7	Parole violation	2
Arson	4	Peeping Tom	1
Auto theft	3	Possess/sell drugs	3
Bad checks	5	Possess firearms	1
Burglary	11	Prescription forgery	1
Child molestation	2	Probation violation	28
Concealed weapon	2	Public drunk	5
Creating turmoil	1	Public indecency	1
Credit card theft/fraud	3	Rape	2
Damage to property	2	Resisting arrest	1
Criminal trespass	10	Robbery	3
Disorderly conduct	7	Injury by vehicle	1
DUI	12	Shoplifting	5
Entering auto	1	Simple assault	3
Expired/suspended license	4	Simple battery	5
False information	3	Terroristic threats	6
Financial transaction	2	Theft by conversion	2
Habitual violator	2	Theft by receiving	3
Harassing phone calls	4	Theft by taking	10
Homicide with vehicle	1	Theft of services	1
Kidnapping	1		

Serious offenses included murder (7), aggravated assault (18), armed robbery (7), burglary (11), rape (2), robbery (3), child molestation (2), auto theft (3), arson (4), homicide with vehicle (1), theft by taking (10), aggravated sodomy (1), terroristic threats (6). There were 28 probation violations.

This study indicates that majority of offenders with past or present mental disorder are involved in serious violent crimes rather than misdemeanors such as public drunkenness, disorderly conduct, or minor trespass charges.

### Psychopathology

Schizophrenia, bipolar disorders, and substance abuse were the major diagnostic categories represented in the Group A. About half of the inmates in this group (N=68) were on psychotropic medication at the time of arrest, and many of them were stable and asymptomatic. Of 138 inmates, 52 were actively symptomatic with hallucinations, delusions, and severe affective manifestations.

Many of schizophrenics and manic-depressives reported using drugs and alcohol; however, some of the inmates with only substance abuse diagnosis were not included

**The prevailing notion has been that severely mentally disabled individuals usually commit non-violent, misdemeanor types of offenses. Our findings negate this notion.**

in the Group A as there was no history of treatment. All the referrals without history of psychiatric treatment had varied symptoms: generalized anxiety, depression, sleep difficulty, or behavior problems. Suicidal ideation and abortive attempts have not been infrequent.

### Discussion

The analysis of data in this study suggests the following:

Relatively large numbers of mentally ill persons, some of them acutely psychotic, are among the inmates of city or county jails. They constitute a major problem of management in such institutions, as they require active treatment for their illnesses.

These persons are often charged with serious and violent crimes. The

prevailing notion has been that severely mentally disabled individuals usually commit non-violent, misdemeanor types of offenses. Our findings negate this notion. Even though our data will not allow us to compare the rate of criminal offenses by the mentally disordered or the substance abuser with the rate of such incidences in the general population, it is realistic to assume that there has been a substantial increase in the numbers of mentally disordered offenders during the past 2 decades because more of them are living in the community.

One of the discouraging observations in this study is the rate of recidivism among the mentally disordered inmates. In the past, it was argued that rate of recidivism in the cases who were found not guilty by reason of insanity was not more than other offenders. Our figures indicate that the recidivism rate for persons with history of MD/SA is greater than for ones without.

The rate of reported positive family history for MD/SA is one of the more significant observations in this study. Our findings underline the fact that the existence of mental disorder and/or substance abuse in the family increases the risk of similar disorder in other members of



the family. Our study does not have the depth and objectivity to draw definitive conclusions on the subject; however, it should provoke curiosity in the psychological and genetic implications of familial psychopathology in mental health and criminology. Further studies in this area may help to identify individuals or groups at risk and may lead to preventive measures.

This study shows the need for comprehensive mental health services in the metropolitan city and urban county jails where large numbers of chronically and acutely ill individuals are incarcerated. Lately, a great deal of emphasis has been placed on mental health services in state prison systems. The development of such services in city and urban county jails, however, where many acutely ill individuals are held has been limited. Many of these facilities offer no more than "band-aid psychiatry" to deal with acutely disturbed, psychotic inmates.

The problem of mentally disordered offenders has reached a crit-

ical point in many communities. More in-depth and controlled studies of this group may provide useful data not only for clinicians and researchers but also for the authorities who are responsible for mental health and offender rehabilitation programs.

## One of the discouraging observations in this study is the rate of recidivism among the mentally disordered inmates.

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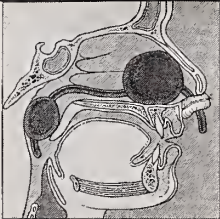
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CUMULATIVE INDEX

## *A Review of the Familial Hyperlipidemias*

*Alice Little Caldwell, M.D.*

**R**OUTINE SCREENING of cholesterol and triglycerides has become commonplace in physicians' offices. When confronted with a child or an adult with elevated cholesterol or triglyceride levels, as defined by levels at or greater than the 95th percentile for age and sex, the physician needs to decide whether the hyperlipidemia is primary or secondary to an underlying disorder. To sort out the various hyperlipidemias, the patient should have blood drawn after a 12-14 hour fast for levels of total cholesterol, total triglyceride, and high density lipoprotein (HDL) cholesterol. Low density lipoprotein (LDL) can be calculated, using the Friedewald formula,  $LDL = \text{Total cholesterol} - (\text{HDL} + \text{Triglycerides}/5)$ , where TG/5 gives an estimate of very low density lipoprotein (VLDL).<sup>1</sup> Having the patient's plasma stand overnight at 4°C will allow chylomicrons to float to the top, forming a creamy layer over a clear infranatant (generally chylomicrons are present only if the plasma triglyceride level is greater than 700 mg/dl).<sup>2</sup> The lipoprotein electrophoresis is generally not necessary to obtain, since it is non-quantitative and mainly useful in determining Type III hyperlipidemia.<sup>1</sup>

**T**his paper will present descriptions of the hyperlipidemias, as classified by

**‘This paper presents descriptions of the hyperlipidemias, as classified by Fredrickson and Levy, and recommendations for a diagnostic approach and treatment.’**

Frederickson and Levy, and recommendations for a diagnostic approach and treatment.

### **Type I Hyperlipidemia**

Type I hyperlipidemia (exogenous hypertriglyceridemia or hyperchylomicronemia), is a disorder characterized by grossly lipemic plasma. There are two separate biochemical defects, both inherited as autosomal recessives, that can result in this condition.

To review, chylomicrons are formed in the microvilli of the proximal small intestine from dietary fat, then released into the

lymphatic system, then into the blood, where the chylomicrons are broken down by an enzyme, lipoprotein lipase, with the aid of apoprotein C-II. Apoproteins are proteins attached to the various lipoproteins, that serve as catalysts in enzymatic reactions and serve as recognition sites for attaching to specific tissue receptors.<sup>3</sup>

Familial lipoprotein lipase deficiency occurs with a frequency of one in a million people, and usually presents before the age of 10, either with acute pancreatitis or with the stigmata of this disease (eruptive xanthomas, hepatosplenomegaly, or lipemia retinalis). The triglyceride level may rise as high as 10,000-20,000 mg/dl. This type of hyperlipidemia, however, is not associated with premature atherosclerosis, a fact that suggests that chylomicrons are not atherogenic, in contrast to chylomicron remnants.<sup>4</sup> Lipoprotein electrophoresis shows excessive chylomicrons, with normal or only slightly increased VLDL, elevated cholesterol, but decreased HDL and LDL. The diagnosis of Type I is made on the basis of the post-heparin lipolytic activity (PHLA) test, that is based on the fact that heparin induces release of lipoprotein lipase and causes a drop in the triglyceride level.<sup>4,5</sup>

The other biochemical defect causing Type I hyperlipidemia is a

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deficiency of apoprotein C-II, a disorder rarely discovered before age 10. These patients do not develop eruptive xanthomas or hepatosplenomegaly, but they do develop pancreatitis when the triglyceride level exceeds 1000 mg/dl. The PHLA is absent or low, but can be normalized with a transfusion of blood or plasma that contains apoprotein C-II.<sup>3</sup>

The treatment for Type I hyperlipidemia is the institution of a low fat diet. No hypolipidemic drugs are effective. For children less than 12 years of age, the dietary fat is restricted to 10-15 grams of fat per day (2-3 ounces of meat per day), with carbohydrates being the major source of calories. Adults should ingest no more than 25-35 grams of fat per day (5 ounces of meat). Medium chain triglyceride oil can be used for cooking since it is directly absorbed into the portal vein. These patients should avoid alcohol.

## Type V Hyperlipidemia

Type V hyperlipidemia is also manifested by markedly increased triglycerides, with both increased chylomicrons and increased VLDL which are formed from endogenous triglycerides. The increase in VLDL is secondary to either an increase in production or a decrease in clearance in VLDL. The disorder may be inherited, although the mode of inheritance is unclear, or may be

secondary to diabetes mellitus, or to alcohol or estrogen use.

These patients usually present at an older age, between the ages of 20 and 50, with either eruptive xanthomas, pancreatitis or lipemia retinalis. Symptoms occur earlier in men compared to women, and may be accelerated by rapid weight gain, diabetes, pregnancy, and alcohol usage.<sup>3</sup>

Whether Type V in itself predisposes the patient to premature atherosclerosis is difficult to assess, since this disorder is associated with other risk factors, such as diabetes. The aim of treatment, to prevent bouts of pancreatitis, should begin with dietary fat reduction to less than 15% of total calories. If diet fails, then either nicotinic acid or gemfibrozil should be tried.<sup>6</sup>

## Type IIa and IIb Hyperlipidemia

Type IIa hyperlipidemia is a disorder characterized by increased total cholesterol and LDL, with normal triglycerides. If the triglyceride level is also increased, the patient has Type IIb.

Familial hypercholesteremia is one of the causes of Type II. It is inherited in an autosomal dominant pattern with a gene dosage effect.<sup>4</sup> The biochemical defect involves the LDL receptor protein, which is critical to the uptake and clearance by hepatic cells of LDL, the most atherogenic of the lipoproteins. Heterozygotes

for this disorder have about 50% of the normal receptor activity and, therefore, have total cholesterol and LDL levels that are about 2-3 times normal. Homozygotes, those patients who received a dose of the abnormal gene from both parents, have no receptor activity and have cholesterol levels 4-6 times normal.

The incidence of the heterozygous form is one in 500 people, with the homozygous form occurring in one in a million.<sup>1</sup> Heterozygotes are generally asymptomatic until the second decade, while homozygotes may develop symptoms, such as planar xanthomas and tendon and tuberous xanthomas, as early as age 5. Both types develop premature atherosclerosis, with angina pectoris and myocardial infarctions occurring as early as the first decade in homozygotes.<sup>4</sup>

A more common cause of Type II is familial combined hyperlipidemia (FCH) which may occur in up to 1% of the population and may account for 10% of patients with coronary heart disease.<sup>6</sup> There appears to be an increase in the major apoprotein of LDL, apoprotein B. FCH is characterized by multiple lipoprotein phenotypes within a single family and may also present as Type IV.<sup>4,6</sup>

Polygenic hypercholesteremia, which accounts for as many as

85% of all Type II patients, does not result from a single monogenic inheritance pattern, but appears to be secondary to a combination of polygenic and environmental factors, including diet.<sup>3</sup>

Secondary causes of Type II hyperlipidemia include hypothyroidism, nephrotic syndrome, and obstructive liver disease. Certain medicines, such as oral contraceptives and hydrochlorothiazide, can also cause rises in total cholesterol and LDL.<sup>3</sup>

The treatment of Type II is initially dietary with reduction in the total amount of fat in the diet, particularly saturated fats, and substitution with polyunsaturated or monounsaturated fats. Certain vegetable oils that are commonly used in nondairy and baked goods, such as palm kernel and coconut oils, are exceedingly high in saturated fat.<sup>3</sup> The bile acid sequestrants alone or in combination with nicotinic acid or lovastatin have been effective in decreasing cholesterol.<sup>7</sup>

### **Type III Hyperlipidemia**

In Type III hyperlipidemia or familial dysbetalipoproteinemia, both cholesterol and triglycerides are increased secondary to delayed clearance of VLDL remnants and chylomicron remnants. The defect involves the gene that specifies the structure of the apoprotein E, which by being attached to the VLDL remnants (or intermediate density lipoprotein, IDL), serves as a recognition site for the removal of these remnants by the liver. Most of the patients with Type III are homozygous for the defective apoprotein. The homozygous state occurs in about 1% of the population, although Type III occurs only in 1 in 10,000 people,

a fact that suggests that other factors must play a role in the presentation of this lipid disorder.<sup>3,4</sup> Hypothyroidism, weight gain, uncontrolled diabetes mellitus and alcohol excess can unmask this disorder. These patients are at increased risk for premature atherosclerosis. Clofibrate, although implicated in increased mortality from noncardiovascular causes in clinical trials, may still be useful in treating Type III.<sup>3</sup>

### **Type IV Hyperlipidemia**

Type IV hyperlipidemia or familial hypertriglyceridemia is manifested by increased triglycerides and increased VLDL with normal total cholesterol and LDL. The defect is in either

**“As more pediatricians and family physicians begin to screen children for cholesterol, more cases of the familial hyperlipidemias will come to light that will necessitate early intervention and treatment.”**

increased VLDL production or in defective VLDL catabolism. Inheritance is autosomal dominant with reduced penetrance.<sup>4</sup> These patients typically express this disorder after puberty or in early adulthood. Fasting triglycerides will be in the 200-500 mg/dl range, but can rise to greater than 1000 mg/dl with excessive alcohol

ingestion or oral contraceptive usage, or with the development of hypothyroidism, obesity, or uncontrolled diabetes mellitus. Eruptive xanthomas are uncommon. Although increased VLDL is not an independent risk factor for premature atherosclerosis, the associated conditions expressed with this disorder place these patients in higher risk categories for early atherosclerosis.<sup>3</sup> Treatment has been primarily with nicotinic acid or gemfibrozil, if diet and weight reduction alone fail and the patient is at increased risk for coronary heart disease.<sup>6</sup>

**D**etailed information on the dietary and pharmacological treatments for the hyperlipidemias can be found elsewhere.<sup>1,3,6,7</sup> There has been limited experience with the use of most these agents in children. As more pediatricians and family physicians begin to screen children for cholesterol, more cases of the familial hyperlipidemias will come to light that will necessitate early intervention and treatment.

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## Progress Against Leukemia

Charles M. Huguley Jr., M.D.

**O**UR PROGRESS in the treatment and cure of the acute leukemias is one of the great success stories of modern medicine. In comparison with the long period of more than a century that we have had success in treating many solid tumors, it is only very recently that we have been able to do anything at all for the acute leukemias.

Historically, effective treatment of cancers began long ago with surgery. Radiation therapy with external beams was begun early in this century and with internal radioisotopes in the 1940s. Chemotherapy first appeared in 1945.

The leukemias are by their nature completely disseminated malignancies at the time of diagnosis and are therefore not conceivably treatable by surgery. Radiation therapy for the treatment of leukemia has to encompass the entire body, either by external whole body radiation or by intravenously distributed internal radiation (radioisotopes). Such radiation has been used for the treatment of leukemia. While it has been used effectively for the treatment of the chronic leukemias, it exerts only a very temporary effect on the acute leukemias. In neither type is radiation therapy alone curative, because the maximum tolerated dose is below that necessary to completely eliminate leukemic cells. Nevertheless, the bone

marrow is the most radiosensitive tissue, and leukemic cells have a steep dose-response curve. Therefore, it has proved possible to eliminate acute leukemia cells or chronic myelocytic leukemia cells by whole body radiation (in combination with some chemotherapy) at a dose which, while it completely destroys the bone marrow, does not produce irrecoverable damage to other tissues. This approach to treatment had to await development of a method to rescue the bone marrow, i.e., marrow transplantation.

Because of the above problems with surgery and radiotherapy, we made no progress toward the cure of the leukemias until the advent of chemotherapy. This has been our major weapon for 40 years. Our progress toward the cure of acute leukemia is one of the victories of the war against cancer. The lessons we have learned along the way have shaped our strategies against other malignancies.

**N**itrogen mustard, an alkylating agent, the first cancer chemotherapy drug, was introduced in 1945 and was

spectacularly successful against Hodgkin's disease. The effect on leukemia was incomplete and transient and generally considered not to be worth the toxicity. Aminopterin, an antifolate agent, was tried against acute leukemia in children by Sidney Farber in 1947 because it had been noted that the newly identified vitamin, folic acid, made acute leukemia progress faster. Aminopterin produced remissions, many of which were complete remissions (CR). Although the disease inevitably recurred in a few weeks or months, this was, nevertheless, a most encouraging advance and set in motion intensive investigations that led to steady improvement that is still continuing. Maintenance with the same drug would prolong the disease-free interval but would not cure. Methotrexate (MTX) soon replaced aminopterin as the preferred anti-folate, because of more predictable toxicity, but the effectiveness was essentially the same.

By 1953, we had added anti-purine drugs, first 6-mercaptopurine (6-MP) and later 6-thioguanine (6-TG), and steroid hormones as effective agents. One patient with acute lymphocytic leukemia (ALL), first treated in 1953, was still in complete remission in 1958, 5 years later. This was the first documentation of an apparent cure of acute leukemia. It appeared that the

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disease was curable and that cure required the availability of more than one drug capable of producing a CR. In the meantime, we had added the periwinkle (vinca rosea) alkaloid, vincristine (VCR) which worked by an entirely different mechanism, destruction of the mitotic spindle. With these several sets of drugs having four different mechanisms of action and four different types of toxicity, the stage was set for combination chemotherapy. In a brilliant analysis using Venn diagrams, Frei and Freireich showed that the combinations of prednisone with 6-MP or with VCR would produce more CRs in patients with ALL than would have been expected from a simple addition of the effects of either drug alone. These drugs were synergistic.

***“In a brilliant analysis using Venn diagrams, Frei and Freireich showed that the combinations of prednisone with 6-MP or with VCR would produce more complete remissions in patients with ALL than would have been expected from a simple addition of the effects of either drug alone.”***

**E**ssential needs for effective combination chemotherapy are: (1) that there be available several drugs having different mechanisms of therapeutic effect which are individually capable of

producing CRs and (2) that these drugs have different target organs for toxicity, so that in the combination each can be given in full dosage without overwhelming toxicity. These first two-drug combinations produced CRs in over 80% of children with ALL and in over half of adults with ALL.

This much was accomplished by the early 1960s. Since then, we have been refining our approach to ALL and working on the acute non-lymphocytic leukemias (ANLL or AML). Drug schedules and theoretic strategies were tested in mouse leukemias and then extended to human leukemias in carefully designed, large scale clinical trials. Nearly all patients with acute leukemia in the last 30 years have participated in clinical trials.

Attaining CR status was not enough, since it meant only that the numbers of leukemic cells had been reduced below the level at which we could detect them, i.e., from about  $10^{12}$  at the time of diagnosis to about  $10^{10}$  at the time of CR. Although this is a drop of approximately 99%, there are still many leukemic cells remaining. This is obviously not good enough. As our results have improved, we have changed our goal from the production and prolongation of “complete remission” to the achievement of “cure.” We have striven to “consolidate” the remission by reducing the numbers of leukemic cells below the level at which the disease could recur, perhaps this means zero, possibly the number may be as high as 100,000 or so.

**S**teady progress has continued. We have added a number of new agents. There are new antimetabolites and new strategies for using them. There is l-asparaginase, an enzyme which

destroys an amino acid important for proliferating leukemic cells. We also have daunomycin, an antibiotic which intercalates DNA. The use of a combination of prednisone, vincristine, l-

***“Steady progress has continued. We have added a number of new agents. There are new antimetabolites and new strategies for using them.”***

asparaginase, and daunorubicin is rather standard for induction therapy for ALL and leads to a CR rate of >90% in children and 70-80% in adults. Consolidation and maintenance schedules vary, but they are intensive and arduous and are carried on for 2 to 3 years. The 5-year disease-free survival rate and presumed cure for children with ALL is >65%. Adults do not fare as well, and age is very important prognostically. Even so, the cure rate in adults is at least 15% and, in a number of recent studies, around 25%.

Success in treating acute myelocytic leukemia (AML) has lagged behind ALL. We have, however, caught up in adults. Children with AML have about the same response and survival rates as adults. The standard induction therapy is a 3-day course of daunomycin concurrent with a 7-day infusion of cytosine arabinoside. We expect close to 80% CR. Subsequent therapy involves many drugs given intensively over many months in various complicated regimens. Success is highly dependent on age, but we are often successful even in patients past 60 years.



The cure rate is at least 20% and more likely 25-30%. Important problems at present are the identification of high-risk patients who need more intensive therapy than usual or early consideration of marrow transplantation.

***‘Bone marrow transplantation has come into prominence recently as the technology and success rate have improved and the morbidity and mortality have been reduced.’***

**B**one marrow transplantation has come into prominence recently as the technology and success rate have improved and the morbidity and mortality have been reduced. The patients are treated very aggressively with agents, usually whole-body radiation and chemotherapy, which destroy their bone marrow, immune system and, it is hoped, all of their leukemic cells. The bone marrow and immune system are then reconstituted with a compatible donor marrow given intravenously.

Marrow transplantation must be considered for adults with acute leukemia who have an ongoing complete remission and for children with AML in first remission or ALL in second remission. Patients in these categories who have an HLA match with a sibling (about 20-25%) will achieve a long-term disease-free survival after marrow transplantation about 50% of the time, albeit after a long, miserable, and expensive hospitalization. This result is

better than we are currently able to obtain with chemotherapy. However in adults, if we wait for the first evidence of relapse before transplantation, we will avoid the need for the rigors of transplantation in about 25% (who will be cured by chemotherapy), and we can expect a good outcome in about a third of the ones in early relapse. Thus, the final outcome may be the same — about a 50% cure.

Unfortunately, only 20-25% of patients will have an HLA-matching sibling. The good news is that marrow from matched unrelated donors works nearly as well. Such donors can often be located through the National Bone Marrow Donor Registry.

Good results are also beginning to be reported from the use of autotransplants. The marrow of patients in complete remission looks normal, but obviously most patients still harbor leukemic cells or else their disease would not recur. Nevertheless, there are not many leukemic cells. Marrow is withdrawn from the patient while in remission and treated with one of several agents which will destroy all or nearly all of the remaining leukemic cells without preventing the ability of the normal stem cells to repopulate the marrow. This treated marrow is then frozen and stored. The patient is given preparatory treatment for a marrow transplantation following which the stored marrow is given back to the patient. This approach is increasingly successful. Not only is the marrow available to all patients, but there is the added advantage that there is no graft-versus-host disease. Therefore, it can be used in patients who are older than the upper limit of age, 40-45, usually set for a sibling marrow transplant.

Thus, we have reached a point where adults with ALL and adults and children with AML achieve a complete remission about 80% of the time, and these will have, under the best circumstances, a cure rate of up to 50%.

**T**he chronic leukemias are a different story. Both chronic myelocytic leukemia (CML) and chronic lymphocytic leukemia (CLL) have been very responsive to a variety of treatments for many years, but they have not been curable. Newer treatments have provided a better quality of life, but they have not led to a cure. Marrow transplantation is curative for many patients with CML who are well controlled early in the disease and have an HLA matching donor available. We have not yet succeeded in curing CLL.

It is important to reflect that the tremendous strides we have made in treating acute leukemia could not have been made without the active participation of thousands of patients with the disease who have gallantly cooperated in investigative protocol studies of treatment. Planned and carefully recorded treatment is a way of life for the physicians who treat acute leukemia, and during the past 30 years, nearly all patients with acute leukemia have been treated on such protocols. As a result, we know more about how to manage this group of diseases than any other disseminated cancer. We are hampered in our progress against these other cancers by the unwillingness of patients to participate and by the failure of their physicians to actively recommend planned investigative studies.

We must also remember that the development and improvement of new drugs and strategies for their successful use

# C A N C E R

***‘We must remember that the development and improvement of new drugs and strategies for their successful use have been absolutely dependent upon the use of animal models. . . . Unfortunately, there is now a well-organized movement threatening to wreck this progress. As if the work were not already difficult enough!’***

have been absolutely dependent upon the use of animal models. Naturally, we go as far as we can with other methods, for humane reasons as well as the tremendous cost of working with animals. Prospective drugs must be tested for antitumor effect on animal tumors, first in the test tube, then in the intact animal. Effective drugs must then be tested in animals for toxicity and approximate dose level. Only then is it justifiable to try the drug in patients with cancer. Unfortunately, there is now a well-organized movement threatening to wreck this progress. As if the work were not already difficult enough!

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## What to Expect — And Not Expect — in the Medicare/Medicaid Anti-Kickback “Safe Harbor” Regulations

Robert N. Berg

THE JANUARY, 1989, Legal Page contained a primer on the Medicare/Medicaid Fraud and Abuse statutes (the “anti-kickback provisions”), which generally prohibit the solicitation or receipt of kickbacks, bribes, rebates, or other remuneration in return for the referral of Medicare or Medicaid patients or services.<sup>1</sup> In that article, we also mentioned the fact that, under the Medicare and Medicaid Patient and Program Protection Act of 1987,<sup>2</sup> the Secretary of the Department of Health and Human Services (HHS), through the HHS Office of Inspector General (OIG), is required to issue final regulations specifying various types of commercial arrangements and payment practices which will *not* be subject to prosecution under the anti-kickback provisions. These regulations must be published in final form on or before August 18, 1989.

Following one aborted attempt — draft proposed safe harbor regulations were issued by HHS on December 22, 1988, and withdrawn 1 day later<sup>3</sup> — the Secretary of HHS has now officially published for comment proposed safe harbor regulations (the “Proposed Regulations”).<sup>4</sup> This article describes briefly the

“safe harbors” included in the Proposed Regulations, as well as certain critical features omitted from the Proposed Regulations.

### “Safe Harbors” Included in the Proposed Regulations

Under the Proposed Regulations, several types of transactions, if properly structured, would fall within the specified “safe harbors” and thus would be exempt from prosecution under the anti-kickback provisions. Specifically, safe harbors would be created for (1) certain types of investment interests, (2) transactions involving the rental of space or equipment, (3) personal services/management contracts, (4) medical practice sales, (5) referral services, and (6) certain types of warranty transactions. Additionally, the Proposed Regulations would provide guidance in interpreting the existing statutory exceptions provided for discounts, employer/employee transactions, and group purchasing organizations. Each of these safe harbors is discussed below.

**Investment Interests.** The Proposed Regulations include a safe harbor for investment interests in large public corporations — corporations having total assets exceeding \$5,000,000 and a class of equity securities held by at least 500 persons. (This is the same “bright

line test” employed by the U.S. Securities and Exchange Commission in determining which companies are required to register with it.) Thus, a physician who invests in a large prescription drug manufacturer or durable medical equipment supplier, for example, need not fear prosecution under the anti-kickback provisions, should that physician also prescribe drugs or equipment manufactured or supplied by those companies to his or her patients. For reasons described below, this very limited safe harbor would not appear to provide much comfort to physicians participating in health care joint ventures.

### Space and Equipment Rental.

The anti-kickback provisions historically have been interpreted broadly enough to cover situations where office space or equipment are leased to physicians at below-market rates, in order to induce the referral of patients to the landlord or an affiliated entity. Where such rental arrangements are legitimate, however, the Proposed Regulations would allow such transactions to take place without prosecution under the anti-kickback provisions. To be legitimate, the rental payment must be based on the fair market value for the space or equipment. Moreover, the transaction must be evidenced by a written lease, and the rental amount must be fixed

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in advance, rather than readjusted periodically based on the number or value of referrals involved.

**Personal Services/Management Contracts.** Under the Proposed Regulations, a safe harbor is provided for personal services and management contracts, if those contracts are set out in writing, specify the services to be provided, provide for a term of not less than 1 year, and provide an aggregate compensation set in advance, consistent with fair market value in arms-length transactions and not determined in a manner that takes into account the volume or value of any referrals of Medicare or Medicaid patients. Also, where the agreement calls for the provision of services on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement must specify exactly the schedule of such intervals, their precise length, their periodicity, and the exact charge for such intervals.

**Sales of Medical Practices.** The Proposed Regulations include an exception for payments made by one practitioner to another practitioner, in conjunction with the sale of the practitioner's medical practice. To fall within this safe harbor, certain prerequisites must be satisfied: The period from the date of the agreement to the completion of the sale must not be more than 1 year, and the practitioner who is selling his or her practice must not be in a professional position to make referrals to the purchasing practitioner after 1 year from the date of the agreement. It should be noted that this is a fairly limited safe harbor, designed to deal with the situation where a physician retires or otherwise removes himself or herself from the practice of medicine in the particular service area involved.

**Referral Services.** A safe harbor would also be created, under the Proposed Regulations, to cover payments by a physician to an entity which offers medical referral services to the public. In order to qualify for this safe harbor, the referral service must be open to any qualified physician, and the fee for participation in the referral service must be charged equally to all physicians and reasonably related to the cost of operating the service. Additionally, the referral service must impose no requirements on the manner in which the physician provides services to a referred person (except for requirements concerning the furnishing of free or reduced-charge services), and the referral service must disclose to each referred person certain information relating to the manner and method by which it makes referrals.

**Warranties.** The Proposed Regulations would provide a safe harbor for situations in which a manufacturer or supplier of medical equipment provides a warranty to the purchaser of the item, as compensation for any loss sustained by the purchaser due to the failure of the item to operate as intended. There must be a written affirmation made in connection with the original sale of the item by the supplier to the purchaser, relating to the nature of the material or workmanship and affirming or promising that the material or workmanship is defect-free or will meet a specified level of performance throughout a specified period of time. Additionally, the amount of the warranty must be reasonably related to the expected economic loss that would be suffered by the purchaser, in the event of a breach of the warranty.

**Statutory Exceptions.** Three exceptions to the general prohibition against kickbacks are

currently included in the anti-kickback provisions: First, this general prohibition is not applicable to a "discount or reduction in price obtained by a provider of services or other entity under the [Medicare or Medicaid statutes] if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under the [Medicare or Medicaid statutes]."<sup>5</sup> In addition, the anti-kickback provisions are not applicable to "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services" under Medicare or Medicaid.<sup>6</sup> Finally, under an amendment added in 1987, the anti-kickback provisions are not applicable to amounts paid by a vendor to a purchasing agent for a group of Medicare/Medicaid providers, so long as there is a written contract specifying the payment calculation and the vendor discloses all such payments to the providers.<sup>7</sup> The Proposed Regulations provide guidance with respect to the application of these statutory exemptions.

### **"Safe Harbors" Not Included in the Proposed Regulations**

Perhaps as noteworthy as the types of transactions included in the Proposed Regulations, there are several types of transactions which were *not* included in the Proposed Regulations. Most importantly, the Proposed Regulations did not include, as permitted "investment interests," participation in limited partnerships and similar types of joint ventures. As exceptions for this type of transaction was included in the first version of the Proposed Regulations (filed for publication on December 22, 1988 and rescinded on December 23,



1988), which would have exempted from the anti-kickback provisions participation in certain types of joint ventures which (i) provided a bona fide opportunity to invest on an equal basis, both to potential referral sources and to others, (ii) contained no requirement for the referral of patients or specimens, (iii) provided for certain mandatory disclosure to referred patients, and (iv) provided payments to the participating investors based upon the amount of the investments, rather than the size or magnitude of the referrals. Again, this was dropped from the final version of the Proposed Regulations, although the Secretary of HHS did invite comments from interested parties, as to the need for such a safe harbor and, if so, the proposed substance of such an exception to the anti-kickback provisions.

Interestingly, the entire issue of the applicability of the anti-kickback provisions to physician participation in joint ventures (*i.e.*, the need for an "investment interests" safe harbor) may become moot, if Congress chooses to enact the Ethics in Patient Referrals Act in 1989. This proposal, originally introduced in 1988 and recently reintroduced by Representative Fournety "Pete" Stark of California, generally would prohibit a provider of Medicare or Medicaid services from accepting patients from a referring physician who (i) has a direct or indirect ownership or financial interest in that provider, or (ii) receives compensation from the provider for services rendered. Current and prospective health care joint venture participants are monitoring the progress of the "Stark Bill" with great interest.

A second provision dropped from the final Proposed Regulations related to the waiver of deductibles for inpatient

hospital care. Essentially, the OIG had recommended that hospitals be allowed to waive any required payment of deductibles for hospital inpatient care (Medicare Part A), without running afoul of the anti-kickback provisions. While a safe harbor for this type of transaction was not included in the Proposed Regulations, the Secretary of HHS did request comments on defining a waiver of deductible safe harbor that would be limited to inpatient hospital care, include only the deductible amount, be available to all Medicare beneficiaries without regard to diagnosis or length of stay, and assure that any costs to the hospital of waiving the deductible would not be passed on to any Federal program as a bad debt or in any other way.

Finally, the original version of the Proposed Regulations included a safe harbor for certain types of physician recruitment activities, where there was a written agreement specifying the benefits and obligations involved, where the term of the agreement was for no longer than 2 years, where the benefits provided to the physicians were not conditioned upon the receipt of patient referrals, and where the agreement was non-exclusive (such that the physician was not barred from obtaining staff privileges at other medical facilities). For unknown reasons, this provision was dropped from the final version of the Proposed Regulations.

## Conclusion

It is anticipated that many physicians, hospitals, and other health care providers and practitioners will take the opportunity to provide comments to HHS on the Proposed Regulations. This, in turn, may result in modifications to the Proposed Regulations, when they are issued in final form this

summer. Moreover, additional changes may result from a report which is required to be prepared and filed with Congress, on or before May 1, 1989, under the Medicare Catastrophic Coverage Act of 1988. This report is designed to disclose the results of a survey by the OIG concerning, among other things, physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the Medicare or Medicaid programs; the range of such arrangements and the means by which they are marketed to physicians; the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and, the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current anti-kickback provisions. Additionally, the final safe harbor Regulations obviously would be impacted by the enactment of the Stark Bill.

In short, it would appear that 1989 may be a very eventful year, in terms of establishing the manner in which various types of activities, such as those described in this article, are regulated under the Medicare and Medicaid programs.

## Notes

1. See, 42 U.S.C. §1320a-7b [formerly 42 U.S.C. §1395nn(b) (Medicare) and 42 U.S.C. §1396h(b) (Medicaid)].
2. Pub. L. 100-93, effective August 18, 1987.
3. See, 53 Fed. Reg., pp. 51856 (December 23, 1988) and 52488 (December 28, 1988).
4. See, 54 Fed. Reg., p. 3088 (January 23, 1989), proposing the addition of a new Subpart E to Part 1001 of the Medicare/Medicaid regulations (42 C.F.R. §1001.952).
5. 42 U.S.C. §1320a-7b(b) (3) (A).
6. 42 U.S.C. §1320a-7b(b) (3) (B).
7. 42 U.S.C. §1320a-7b(b) (3) (C).

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**Contraindications:** VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions: General: Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium ( $> 5.7$  mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

### Information for Patients:

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions:

**Hypotension: Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of  $^{14}\text{C}$  enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**Hypertension:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**Heart Failure:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction, rhythm disturbances; atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostatic hypertrophy.

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia, an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

### Clinical Laboratory Test Findings:

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration: Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance  $> 30$  mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance  $\leq 30$  mL/min (serum creatinine  $\geq 3$  mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium  $< 130$  mEq/L) or with serum creatinine  $> 1.6$  mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6V518R(15)

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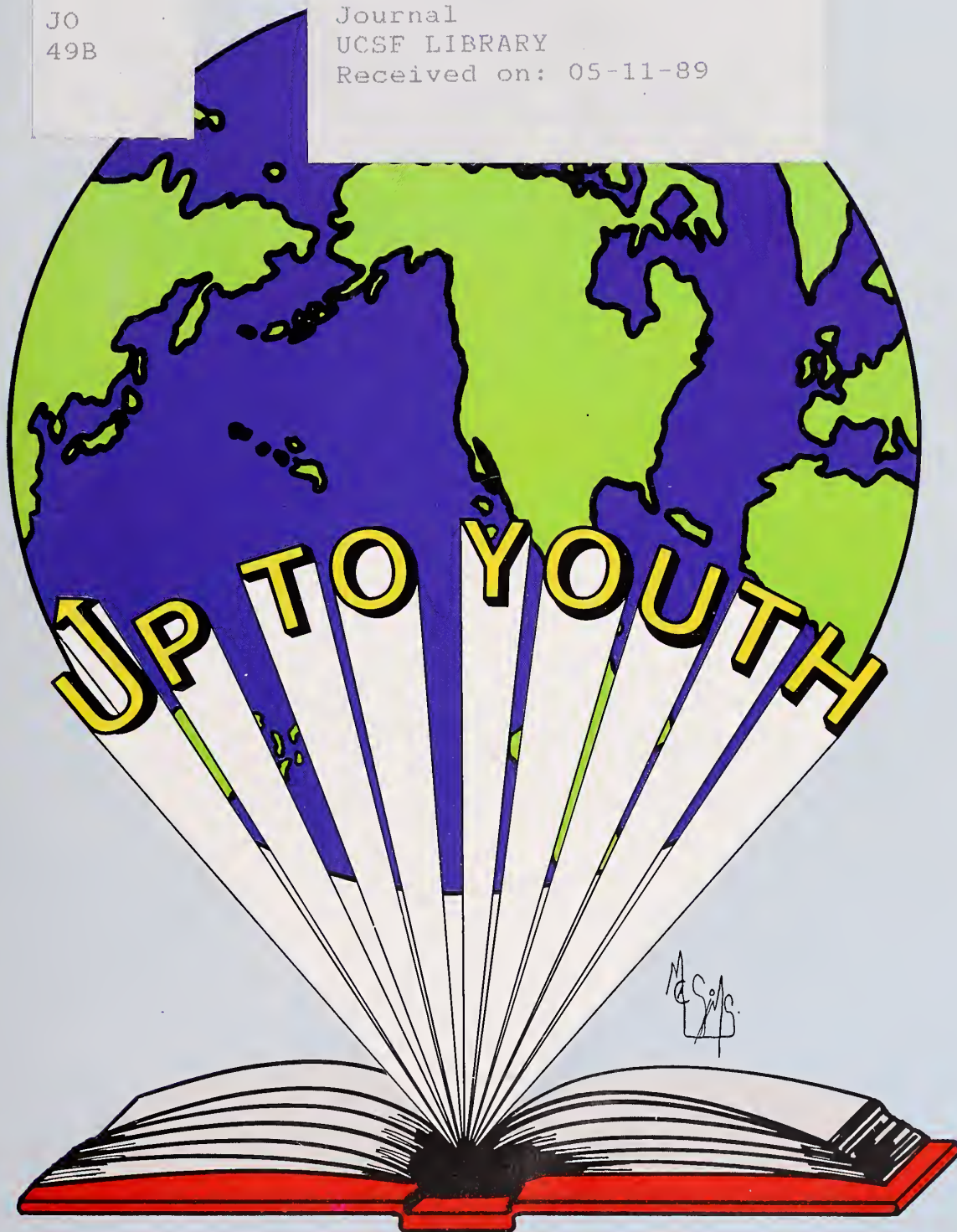


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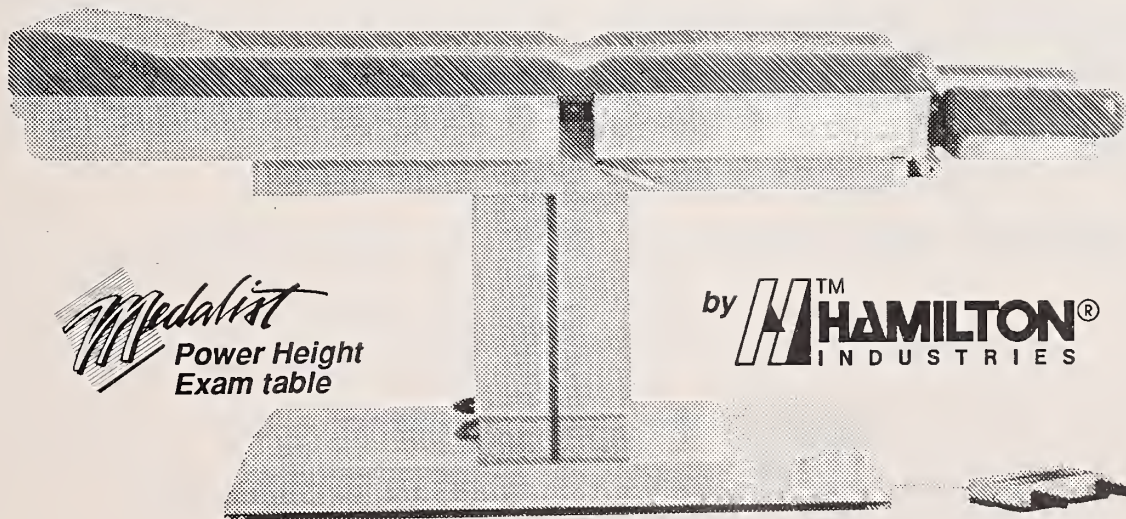
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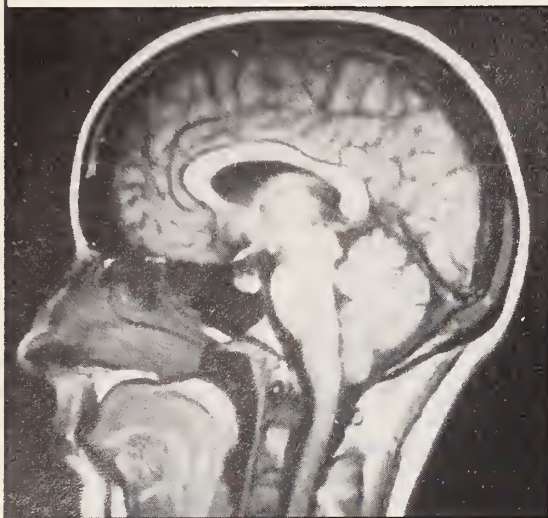
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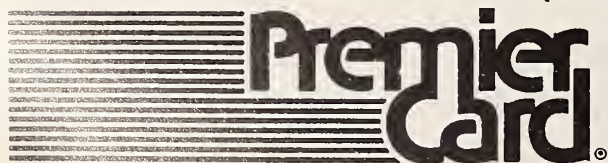
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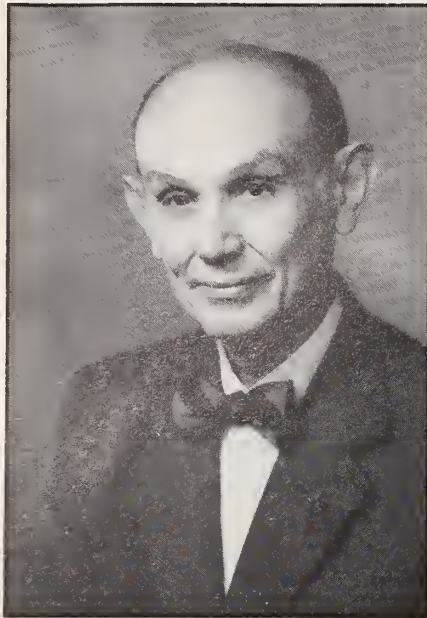
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THE COVER

The art of this month's cover was created by Mac Sims, currently a junior at Valdosta State College, for A-MAG's teen health forum held last March at the University of Georgia. Mr. Sims said of this design concept, "The motto 'UP TO YOUTH' implies that not only American youth but the youth of the entire world hold the destiny of the world. The actions of the youth determine how the world is maintained. 'UP TO YOUTH' extending from a book symbolizes the importance of knowledge in the maintenance of the world."

Highlights of the Teen Health Forum begin on p. 250.



*Joseph P. Bailey, Jr., M.D.*

## *Closing Thoughts*

**A**NOTHER YEAR in the history of the Medical Association of Georgia has been completed. For me, it represents one of the greatest honors to have served as your president. I do humbly and sincerely thank each of you for this privilege.

What are my conclusions from the year just past?

One thing that is a certainty, is that we are practicing medicine in a setting that is greatly influenced by public demand, policy, governmental controls, and ultimately by legislative change at the state and national level. We must intervene to actively support our position as the guardian of the health and medical well being of our country's people.

As a part of this effort, we must ensure that everyone is aware of the vast educational background we have individually acquired and the ongoing educational effort that is indigenous to our very being.

We must continue to make it blatantly apparent that we represent a profession of the very

highest calibre and not a trade. We must convey the reality of our concern for our fellow man that is not mediated by monetary objective while maintaining the capacity for adequate income.

**I**t must be shown that the cost of care is greatly influenced by legitimate patient need and demand as well as inflation, coupled with medical liability premium requirements. The increase in our nation's population and in its older age groups produces absolute need for more medical care.

Research is an essential component of medicine and improved care; but again, research is not the product of only an informed and inquiring mind but also of monetary support.

Amidst all of this we must make it attractive for the best of our youth to enter the medical field. As a trust of our profession, we cannot lower the standards of acceptance to accomodate artificial numerical objectives. This will ultimately worsen the

plight of the American public and decrease its trust in us.

Of great value is to recognize the sacrifice of self that is required of the physician. This is represented in many tangible and real ways. We must all ensure our physical and mental well being by organized effort to guarantee programs of individual nature that will provide our maximal health to make it possible to help others. This includes time for our families, friends, and ourselves. We must demonstrate not only our concerns for our patients but also for our fellow physicians. We are our brother's and sister's keeper.

**A**nd so it is my belief that we, as all humans in the past, are now confronted with new problems, challenges, and opportunities. Let us all join together in the unity of our profession to move against the wrong, support the right, and do so with tempered judgment, intelligence, kindness, and love of God and man.

*Joseph P. Bailey, Jr.*

1988-89 MAG President





## Curtain Call

**"Getting Our Act Together and Taking It On the Road"** has been the theme of the 1988-89 auxiliary year. Our philosophy is that before we can educate the community and schools in good health care, before we can help elevate the image of the physician in the community, and before we can lobby for Georgia health legislation, we must prepare our scripts and rehearse our parts in order to give our finest performances.

The Auxiliary to the Medical Association of Georgia has literally a "cast of thousands" playing the many difficult roles required of the physician's spouse. This special Auxiliary Issue of the *MAG Journal* will showcase some of these scenes.

"It's Up to Youth" is the "star" of our auxiliary year. This highly successful Teen Health Forum at the University of Georgia is our feature article in this issue. Please note the beautiful original drawing on the cover that was our official logo.

In addition to adolescent health, our emphases have been in the fields of legislation, team efforts with medical societies, and medical heritage. We hope you will read and enjoy all of these and more articles written by auxiliarians and compiled by Allyce



Jan Collins

North, an A-MAA member and guest editor of this issue.

Our county auxiliaries have been extremely active and productive this year in a variety of projects geared to their individual communities. When you read in this issue what some of these auxiliaries have accomplished, you will see why Dr. Joe Bailey announced at the AMA-Auxiliary Conference in Chicago, "I just wish the rest of the states in America had clones of our auxiliarians in Georgia to help you get the job done!"

A million thanks to the Medical Association of Georgia for the confidence you have placed in your State Auxiliary. We appreciate the support you have given us — moral, financial, and physical. We trust that you feel that your investment in the Auxiliary has paid off. We, the physicians' spouses, join you every step of the way in your campaign to protect the public, to ensure good health care delivery, to educate the community in healthy lifestyles, and to support the family of medicine.

1988-89 Auxiliary President

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Rogers, Stephen E., Anesthesiology/Family Practice — Georgia Medical — (Active) Dept. of Anesthesiology, Memorial Medical Center, P.O. Box 23089, Savannah 30033

Sinha, Ranjit, Psychiatry — Ocmulgee — (Active) 507 Griffin, Eastman 31023

Stammers, Thomas W., Anesthesiology — Bibb — (Active) 3500 Riverside Dr., Macon 31210

Strickland, Robert S., Sr., General Practice — Cobb — (Active) 292 Bankhead Highway, Mableton 30059

Turner, James H., Psychiatry — Glynn — (Active) 111 Harrogate Rd., St. Simons Island 31522

## PERSONALS

### Bibb CMS

*Rodney M. Browne, M.D.*, an obstetrician/gynecologist, has been re-elected as the 1989 chairman of the board for the HCA Coliseum Medical Centers board of trustees. Dr. Browne has been a part of HCA Coliseum Medical Centers since 1971, when the hospital opened.

### Georgia Medical Society

*Manohar Nallathambi, M.D.*, of Jonesboro, was elected as a fellow of the American Association for the Surgery of Trauma at its annual meeting in California.

### Gwinnett-Forsyth

*Michael Joel Kalston, M.D.*, of Cumming, has been inducted as a fellow of the American Academy of Orthopaedic Surgeons during ceremonies at the Association's 56th annual meeting in Las Vegas.

### DeKalb CMS

The 1988 Julius McCurdy Citizenship Award was presented to *Harry Foster, M.D.*, at the recent Annual Meeting of the DeKalb Medical Society. Dr. Foster is a pediatric cardiologist in Lithonia.

Dr. Foster was honored for his service to his community. He has served as team physician for the athletic program of Lithonia High School since 1964 and has provided more than 6,500 pre-participating athletic physicals at no charge. He is a member of the Lithonia Quarterback Club, the Lithonia 150 Gold Club, the Lithonia High School Band



Booster Club, and he recently completed 2 years of service as president of Lithonia High School's PTSA.

He has served on DeKalb County School Systems' Committee on Discipline and was awarded life membership in the Lithonia School PTA. He received the Positive Parenting Award in 1988 and the Friend of Children Award in 1986. Dr. Foster has also served as director of the Children's Medical Services' Atlanta Cardiac Program since 1965. Four times per year, he staffs the Children's Medical Cardiac Clinic in Columbus.

## Medical Association of Atlanta

Robert F. Finegan, M.D., an anesthesiologist at South Fulton Medical Center, received the Crawford W. Long Distinguished Service Award by the Georgia Society of Anesthesiologists last February.

Dr. Finegan, a charter medical staff member of the Medical Center, has served as both chief of anesthesiology and chief of staff. He has been active on numerous committees within the Georgia Society of Anesthesiologists. He was also on the first American Heart Association committee for CPR in 1966 and has remained active to promote the CPR program throughout the state.

## Whitfield-Murray CMS

Robert Burns, M.D., was recently elected president of the Whitfield-Murray County Medical Society. Also elected were John Antalis, M.D., vice president; William Blackman, M.D., secretary-treasurer. Stefan Fromm,

M.D., will serve as immediate past president.

## DEATHS

W. Mark Coppage, M.D., of Lawrenceville, died last March in Seagrove Beach, Florida, of injuries sustained in a multi-vehicle accident. He was 45.

Dr. Coppage was a native of Macon and a graduate of the Medical College of Georgia. He had been with the DeKalb Anesthesia Associates, P.A., since 1974. Certified by the American Board of Anesthesiology, Dr. Coppage had served on the active medical staff of DeKalb Medical Center and the Decatur Hospital.

## OTHER NEWS

### Patients With Myasthenia Needed for Emory Study

The Department of Neurology at Emory School of Medicine has begun two clinical trials of cyclosporine in myasthenia gravis. In one study, the drug is being analyzed as an alternative to prednisone in those patients who require treatment other than Mestinon. The second study evaluates cyclosporine in patients on prednisone as an alternative to immunosuppression with azathioprine (Imuran). Patients will be requested to return to Emory for lab and clinical monitoring monthly for 12 months at no expense to them. To schedule a screening examination or to obtain additional information, call Linton C.

Hopkins, MD, at 404-321-0111, ext. 3452, or Meraida Polak, RN, Study Coordinator, at ext. 3754.

## QUOTES

*There are almost as many forms of recreation and diversion as there are human beings. But it can be laid down as a universal rule that every man, woman and child needs some kind of recreation, some kind of entertainment, some kind of amusement. We all have to fight the battle of life. Whether we use our leisure to recreate power or dissipate power is of decisive moment.*

B. C. FORBES

*A man should work eight hours and sleep eight hours but not the same eight hours.*

ELMER G. LETERMAN

*Everyone has a code of ethics for everyone.*

ROBERT HALF

*Gossip is when you hear something you like about someone you don't.*

EARL WILSON

*I have no enthusiasm for nature which the slightest chill will not instantly destroy.*

GEORGE SAND

*Respectability: The offspring of a liaison between a bald head and a bank account.*

AMBROSE BIERCE

*Anybody who believes that the way to a man's heart is through his stomach flunked geography.*

ROBERT BYRNE

## On Giving Up

*(To the Auxiliary, with apologies to the male members thereof, for they are outnumbered.)*

I WAS DRIVING through maddening city traffic, unconscious to the confusion around me, a survival technique essential to a moderately sane existence in the modern metropolis, when the serious and concerned female voice from the radio speaker addressed me. "Teenagers do not bring their problems to you in the usual way. They don't say, 'I'm stressed out, Mom.' Rather they bring their problems to you in the form of poor school grades. Or by withdrawal from family associations. Or by forming questionable social alliances."

Surely, I knew these facts. Who in the course of raising five children, or one for that matter, did not. It goes, so it is said, with the territory. Such knowledge may come to one by way of reading or conversation. To some of us it comes directly.

She went on, the feminine voice from the speaker, to tell me the name of the hospital to which I might send, might "refer," my "child." It was in a city distant to my own. Little concern to me, they were grown, our own five were, and beyond the hazards of childhood. Or were they?

She had called the previous evening, my nurse friend of longstanding, to talk about her

"child" now grown to manhood. He had been adopted when the usual course to parenthood had failed them. There had been "behavioral problems" early in the teenage years. "He matured late," she said. Serious enough, however, to require professional help and "institutional care" for a short time. Of immediate concern at present, and prompting the telephone call, was that of an incarceration by the authorities for "trafficking in cocaine with the intent to sell." Five months in the local penal institution simply awaiting the decision for punishment. It seemed punishment enough, that incarceration, she said to me. "The mills of God grind slowly, but they grind exceedingly small," I told her. No comfort this to the distraught mother. Five months in a cell, on a hard mattress. A room shared with three accused murderers and a rapist. "He won't be the same 'child' when he comes out," she said.

"Why don't you give up?," I asked her. "He has caused you enough grief. Embarrassed you and your husband before your friends. Destroyed your savings. You have done your part, sacrificed enough. Quit!" I made the pronouncement with the authoritative, knowledgeable, and cavalier manner of the male animal.

The response came quickly. "You don't understand. I'm his

mother. I love him. He is a good 'boy.' I will never 'give up.' I will never 'quit.' Please try to understand me." She reminded me of Winston Churchill.

It was, or so they say, his most brief public address. Perhaps the most brief ever by anyone. He had stood before the audience following the lengthy and laudatory introduction. The thunderous applause had faded away. The "address" began. He had said to them:

"Never — never — never — give up!"

And then he sat down.

Of course, surely, I did not understand. I find myself yet a "child" hopelessly plumbing the mysterious depths of concern, of energy, of love that drives such people to wash dishes and clothes at midnight. To protect and preserve an errant husband. To continue loving a "hopeless" child in the face of disaster. "Understanding" is of no matter now. Admiration, respect, majestic awe are enough for me. One has no need to "understand." No more than to "understand"

Womanhood —

Motherhood —

Sunsets —

A loving mother —

A broken heart.

One need only stand in awe.

CRU



# HELPING TO ACHIEVE THE FOUR GOALS<sup>1</sup> OF ANTIHYPERTENSIVE THERAPY...



**NEW**

**CARDIZEM<sup>®</sup> SR**  
(diltiazem HCl) sustained release capsules

*For hypertension*

**Controls blood pressure<sup>2-6</sup>**

**Maintains well-being<sup>2-6</sup>**

**Helps prevent end-organ complications<sup>7,8</sup>**

**Helps reduce cardiovascular risks<sup>2,5,9</sup>**

**90 mg SR bid**



## Starting Dosage:



**90 mg bid\***

**Also Available:  
120-mg capsules**

\*Dosage must be adjusted to each patient's needs, starting with 60 to 120 mg twice daily.

### BRIEF SUMMARY CARDIZEM® SR (diltiazem hydrochloride) Sustained Release Capsules

#### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

#### WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LHO, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in some cases, but probable in some. (See PRECAUTIONS.)

#### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Dermatological events (see ADVERSE REACTIONS section)** may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

**Drug Interaction.** Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment,

may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

**Beta-blockers:** Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

**Cimetidine:** A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

**Digitalis:** Administration of CARDIZEM with digoxin in 24 healthy male subjects increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

**Anesthetics:** The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

#### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing. The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system; these include any adverse reactions seen in angina studies that were not observed in hypertension studies. In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie, greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%).

**NEW**

# CARDIZEM® SR

(diltiazem HCl) sustained release capsules

*For hypertension*

**EFFECTIVE MONOTHERAPY  
WITH HIGH  
PATIENT ACCEPTANCE**



#### DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS

Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)
ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
syncope	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) or have been observed in angina trials. In many cases, the relation to drug is uncertain.

**Cardiovascular:** Angina, arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.

**Nervous System:** Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor, abnormal dreams.

**Gastrointestinal:** Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT, and LHO (see hepatic warnings), vomiting, weight increase, thirst.

**Dermatological:** Paresthesia, pruritus, photosensitivity, urticaria.

**Other:** Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarthritis pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

**References:** 1. Staessen J, Fagard R, Lijnen P, et al: *Pract Cardiol* 1986;12(5):55-65. 2. Massie B, MacCarthy EP, Ramanathan KB, et al: *Ann Intern Med* 1987;107(2):150-157. 3. Weir MR, Josselson J, Giard MJ, et al: *Am J Cardiol* 1987;60:361-411. 4. Frishman WH, Zawada ET Jr, Smith LK, et al: *Am J Cardiol* 1987;59:615-623. 5. Pool PE, Seagren SC, Salel AF: *Am J Cardiol* 1985;56:86H-91H. 6. Pool PE, Seagren SC, Salel AF: *Cardiol Board Rev* 1986;3(10):77-91. 7. Sunderrajan S, Reams G, Bauer JH: *Hypertension* 1986;8:238-242. 8. Amodeo C, Kobrin I, Ventura HO, et al: *Circulation* 1986;73(1):108-113. 9. Schulte K-L, Meyer-Sabellek WA, Haertenberger A, et al: *Hypertension* 1986;8:859-865.

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# CALENDAR

## MAY

18-20 — *Jekyll Island: Georgia Rheumatism Annual Meeting.* Category 1 credit. Contact Richard S. Field, M.D., Section of Rheumatology, MCG, Augusta 30912. PH: 404/721-2981.

19-21 — *Destin, FL: Georgia Radiological Society Annual Meeting.* Category 1 credit. Contact Lloyd B. Schnuck, Jr., M.D., 9 Medical Arts Center, Savannah, GA 31405. PH: 912/242-8090.

22-25 — *Atlanta: American College of Obstetricians & Gynecologists.* Category 1 credit. Contact A.C.O.G., 409 Twelfth St., Washington, DC 20024-2188; PH: 202/638-5577.

24-26 — *Calloway Gardens: Perinatology Conference.* (Sponsored by The Medical Center in conjunction with the Dept. of Pediatrics & Ob/Gyn.) AMA Category 1 credit, ACOG, AAFP, & PREP prescribed credits. Glenda Driscoll, 710 Center St., Columbus 31994. PH: 404/571-1692.

## JUNE

12-15 — *Hilton Head Island, SC: Clinical Cardiology.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

19-24 — *Kiawah Island, SC: 20th Annual Internal Medicine Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-25 — *Sea Island: GA Chapter, American Academy of Pediatricians.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30342. PH: 404/237-3922.

23-25 — *Hilton Head Island, SC: Daily Anesthetic Challenges.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## 26 — Atlanta: Breast Cancer: Conservative Treatment.

Category 1 credit. Contact Donna Cannon, HCA West Paces Ferry Hospital, 3200 Howell Mill Rd., NW, Atlanta 30342. PH: 404/350-5600.

28-July 2 — *Nairobi, Kenya: 4th International Interdisciplinary Conference on Hypertension in Blacks.* Category 1 credit. Contact International Society on Hypertension in Blacks, 69 Butler St., Atlanta 30303. PH: 404/589-5810.

29-July 2 — *Kiawah Island, SC: Hematology-Oncology — Recent Advances.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## JULY

10-12 — *Kiawah Island, SC: Update in Gynecology.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

13-15 — *Kiawah Island, SC: Clinical Obstetrics.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-22 — *Kiawah Island, SC: 11th Annual Critical Care Medicine.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

24-26 — *Kiawah Island, SC: 12th Annual Pediatric Update.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## AUGUST

10-13 — *Hilton Head, SC: Georgia Psychiatric Physicians Association.* Category 1 credit. Contact Jim Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

## SEPTEMBER

15-17 — *Augusta: Clinical Psychiatry.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

21-23 — *Hilton Head, SC: Frontiers in Nutrition.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## OCTOBER

5-6 — *Atlanta: GA Chapter, American Academy of Pediatrics.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30346. PH: 404/237-3922.

9-11 — *Savannah: Neonatology — The Sick Newborn.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

29-Nov. 3 — *Sea Island: Georgia Obstetrical & Gynecological Society.* Category 1 credit. Contact Chester Lane, 69 Butler St., Atlanta, 30309. PH: 404/659-0289.

## NOVEMBER

9-11 — *Atlanta: Georgia Academy of Family Physicians.* Category 1 credit & AAFP prescribed. Contact GAFFP, 3760 LaVista Rd., #100, Tucker 30084. PH: 800/392-3841.

10-12 — *Atlanta: Gastroenterology for Primary Care Physicians.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

17-19 — *Atlanta: MAG Scientific Assembly.* Contact MAG, Dept. of Education, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.



## Hospitals See Good Outcomes From 1989 Legislature

As the Legislature's hour glass ran out March 15, Georgia's hospitals could count a number of positive actions taken during the 1989 General Assembly. Through the work of the Georgia Hospital Association, the legislators funded nearly all of GHA's high priority budget requests, including the following:

- *Hospitals' basic rate change.* Beginning April 1, 1990, Georgia will adjust hospitals' Medicaid rates by the full Data Research, Inc., inflation factor. The rates will stay tied to hospitals' 1987 cost year reports which need to change next year.

- *Medically needy, aged, blind, and disabled.* The legislators voted to increase the number of persons eligible for Medicaid by allowing the working poor to deduct their health care bills from income. This will help some 5,000 people qualify for benefits who were denied in the past because their Social Security check or other income was a few dollars over the limit.

- *Swing beds.* Effective Jan. 1, 1990, Medicare will pay for nursing care in hospitals with fewer than 100 beds. In addition, the legislators increased hospitals' outlier payments and funded pre-admission review.

Other bills that passed the legislature included the following:

- *Indigent care study commission.* The legislators created a 29-member Access to Health Care Commission that will include three senators, three representatives, three hospital administrators, two physicians, and representatives from nursing,

counties, insurance, and business. The purpose of the commission is to design a plan to resolve the indigent care problem.

- *Living Wills.* Hospital physicians other than the chief of staff may witness a living will.

- *Open Meetings.* Hospitals may have private records and meetings that involve "a potentially commercially valuable plan, proposal, or strategy that may be of competitive advantage in the operation of the authority."

- *Health Professions Shortage Study Commission.* This commission will study the shortage of health care professionals in Georgia.

- *Risk Pools for Uninsurables.* Legislation creating a program passed, and development can begin this next year. It will be necessary to obtain state funds to meet premium short fall before the insurance is made available.

## New HHS Secretary Affirms President's Stand on Medicare

U.S. Department of Health and Human Service's new secretary Louis W. Sullivan, MD, has spent much of his first weeks in office supporting the president's proposed \$5 billion cuts in Medicare for fiscal year 1990. Sullivan stresses that Medicare can't continue to see a 14% annual growth.

Whether the president will get the cuts remains another question, however, as the chairman of the House Ways and Means Committee, Dan Rostenkowski (D-IL), has said that the proposals aren't feasible and "do not have congressional support on either side of the aisle."

The president has proposed that more than 70% of the cuts come from Medicare payments to hospitals.

## Medicare Losses Reach \$266 Per Patient

A new Georgia Hospital Association report on Medicare payments to hospitals projects that hospitals will lose from \$165 to \$266 on every Medicare patient this year.

Since 1986, hospitals' Medicare payments have consistently covered less and less of Medicare costs, the study shows, with the brunt of the shortfall being felt by the state's smaller hospitals. Institutions with fewer than 100 beds saw a .05% Medicare loss in 1986, growing to a 4.24% loss the following year, a 6.94% loss in 1988, and a projected 9.6% loss for this year. In actual dollars, that translates to a \$266 loss for every Medicare patient those hospitals treat in 1989.

Though larger institutions haven't seen such a dramatic loss, their Medicare payments reflect the same downward trend. Projections for 1989 are that hospitals with 250 to 399 beds will see a 6.23% loss on Medicare (or \$261 per patient), and hospitals with 400 beds or more will experience a 3.39% loss (or \$165 per patient).

The study was conducted for GHA by Health Care Investment Analysts, Inc., of Baltimore, MD. The hospital association points out that the Medicare shortfall, coupled with the even greater payment deficits of Medicaid and the large number of indigent patients, is why health care costs and insurance rates are high.

## The Price We've Paid

Rise up from prosaic bonds of fear  
Abandon your bias and your hate  
Acknowledge your love for those who are dear  
Proclaim your strength, do not hesitate.

There are those who whimper and fall aside  
Afraid to face the perversity ahead.  
Advance in victory over self pity and pride  
And crush those cowardly faults we dread.

The day will come when we'll all join hands  
And close the breach that man has made  
As peace will reign over all the lands  
And tears will flow at the price we've paid.

## Nostalgia

Was it only yesterday that I watched them talk  
The folks that seemed so old to me?  
They spoke of days long since passed  
No mention of the future or what could be.

I thought it odd that only things now gone  
Could be the best there ever has been.  
But now I can see as the years go by  
How bright the past glows as the future grows dim.

JOHN C. HOUSE, M.D.  
*Family Practitioner*  
*Winder*

*We invite contributions to this Department. Please send them c/o the Journal,  
938 Peachtree St., Atlanta 30309.*



# COMMITTED TO EXCELLENCE



**PRESIDENT'S  
ACHIEVEMENT  
AWARD**

## **Presenting the winners of the 1989 Roche President's Achievement Awards**

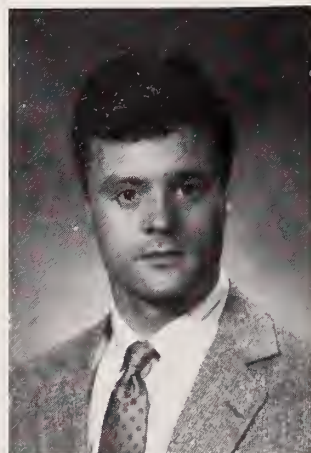
Roche Laboratories is proud to honor these outstanding sales representatives, chosen for their unparalleled dedication to the health-care field, professionalism and consistent high level of performance. Please join us in congratulating these exceptional individuals.



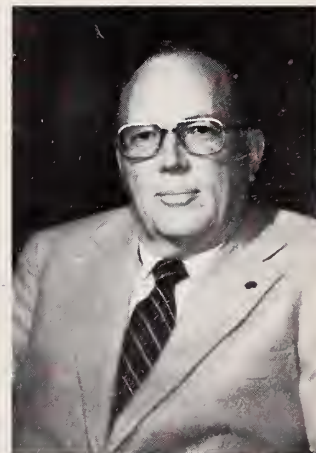
Joseph A. Cogbill



Joseph B. Edwards



Kris J. Knowles



Ralph J. Veal

Turn to the following page and find out how your award-winning Roche representative can help both you *and* your patients.

# YOUR ROCHE REPRESENTATIVE WOULD LIKE YOU TO HAVE SOMETHING THAT WILL ...

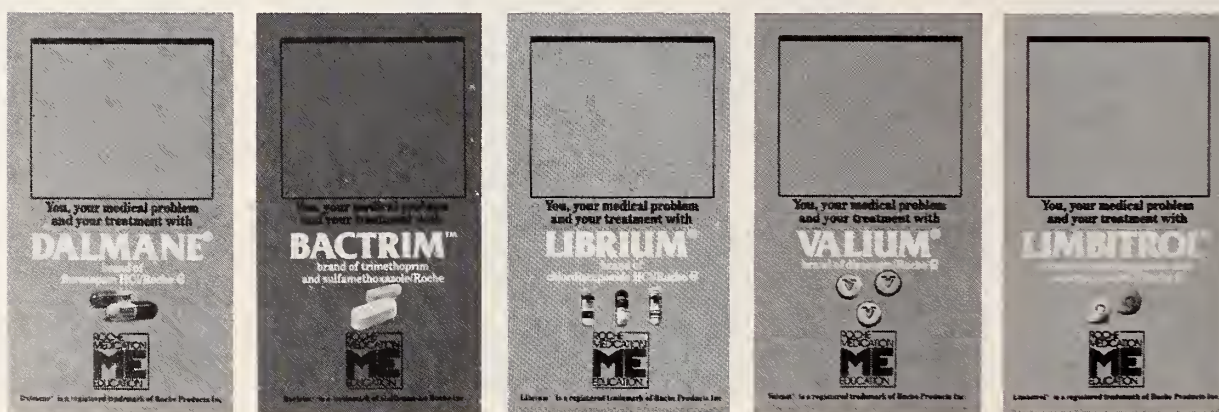


- ... improve patient satisfaction with office visits.
- ... improve patient compliance with your instructions.
- ... reduce follow-up calls to clarify instructions.

## Roche product booklets ...

- offer a supplement to, not a substitute for, patient contact.
- support your specific instructions to the patient.
- provide a long-term reinforcement of your oral counseling.
- are available in *Spanish*.

Because you are the primary source of medical information for your patients, we invite you to look over the Roche product booklets shown below. Ask your Roche representative for the new catalog brochure of patient education materials and for a complimentary supply of those booklets applicable to your practice.



Working today for a healthier tomorrow



# AXID®

## nizatidine

### Enhances compliance and convenience

#### Patients appreciate Axid, 300 mg, in the Convenience Pak

#### In a Convenience Pak survey (N = 100)<sup>1</sup>

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

#### Pharmacists save time – at no extra cost

- The Convenience Pak saves dispensing time and minimizes handling

#### The Convenience Pak promotes patient counseling

- Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction



### Convenience Pak is available at no extra cost



Eli Lilly and Company  
Indianapolis, Indiana  
46285

**AXID®**

nizatidine capsules

**Brief Summary**

Consult the package literature for complete information.

**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.  
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests** – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

**Drug Interactions** – No interactions have been observed between Axid and theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility** – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the recommended dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy – Teratogenic Effects – Pregnancy Category C** – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effects. But, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spinal edema, hydrocoelium, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers** – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

**Pediatric Use** – Safety and effectiveness in children have not been established. **Use in Elderly Patients** – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.1%), and somnolence (2.4% vs 1.5%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic** – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular** – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**CNS** – Rare cases of reversible mental confusion have been reported.

**Endocrine** – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

**Hematologic** – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumentary** – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity** – As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (e.g. bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other** – Hypertrichemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

**Signs and Symptoms** – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

**Treatment** – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP

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Additional information available to the profession on request.

<sup>1</sup> Data on file; Lilly Research Laboratories.



# "It's Up To Youth"

## A Teen Health Forum

Barbara Tippins

**B**ALLOONS, BANDS, banners, box lunches, beautiful weather, and a setting on the campus of the historic University of Georgia are the makings of a very special day! And a very special day was what the Auxiliary to the Medical Association of Georgia had in mind when they envisioned a teen health forum.

### Why A Teen Health Forum?

Teens have been identified as a segment of society whose health has not improved over the years but is fraught with problems instead. The American Medical Association (AMA) was concerned with this situation and conducted a study to ascertain why it existed. AMA then requested that state medical societies and auxiliaries give top priority to adolescent health.

Realizing that the problems facing the adolescent population of Georgia are monumental and many faceted and armed with statistics and a real concern for the health and welfare of the youth, Mrs. Jan Collins, President of the Auxiliary to the Medical Association of Georgia (A-MAG), Mrs. Connie Menendez, A-MAG Health Project Chairman, and the author, A-MAG Adolescent Health Chairman, set out to design a forum aimed at adolescent health improvement. The goals of the program were:

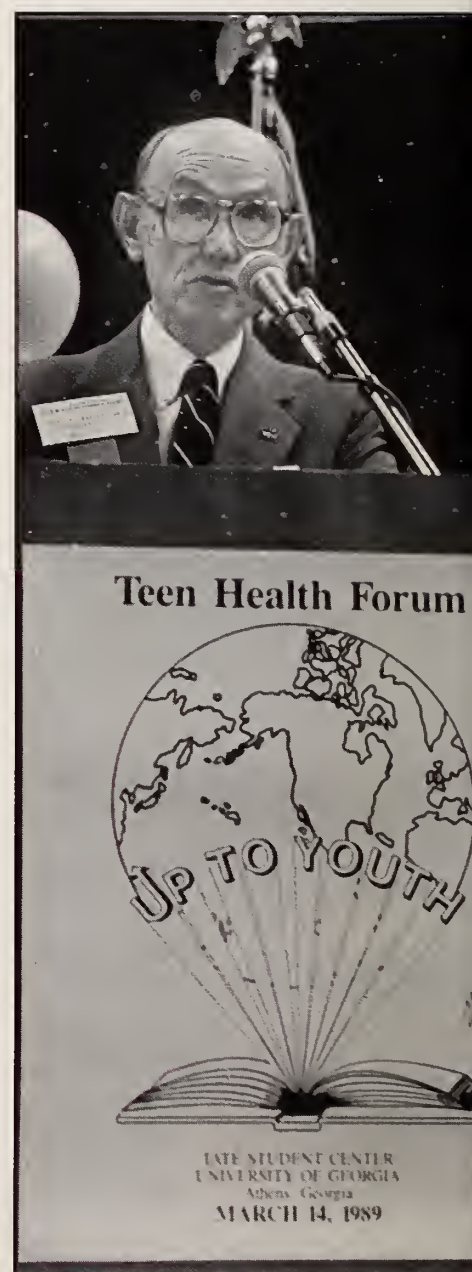
- 1) To educate the young people and their instructors on the true facts of teenage problems.
- 2) To offer alternate lifestyles for improved health.
- 3) To encourage the participants to return to their schools and develop a program which would share the information they had gleaned.

The entire format of the program was envisioned as an upbeat one, educational, positive and supportive, with elements of entertainment and fun included to make the event memorable. Designed around methods of gaining self-esteem, developing decision-making skills, and choosing healthy lifestyles, the forum was to be a way for teenagers to openly discuss the pressures that lead to negative behavior.

In order for the program to be successful, a strong commitment and involvement from the physicians was necessary. When she addressed the MAG Board of Directors, Mrs. Collins outlined the two-fold plan:

*(Continued on p. 252)*

Barbara Tippins (Mrs. William) is a Past President of A-MAG. She currently serves as Chairman of the Adolescent Health Committee and is a nominated Southern Director for the AMA auxiliary. Mrs. Tippins and Mrs. Connie Menendez co-chaired the "It's Up To Youth" teen health forum.

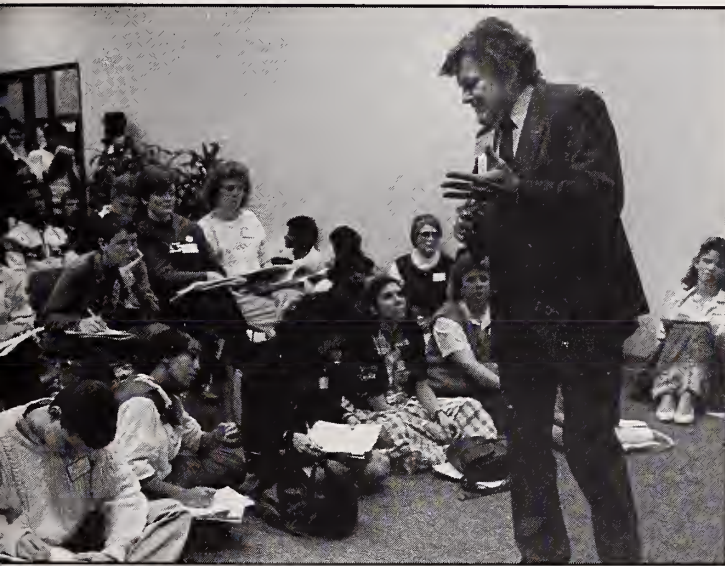


1988-89 MAG President, Joe Bailey, M.D.





*Teresa Edwards, a student at UGA, inspired the students by sharing her experience of winning an Olympic Gold Medal in basketball.*



*Dr. Ed Fowler speaks to a group of teens in the workshop he led on postponing teen sex.*



*Crawford Long auxiliaries distribute lunches to the students attending the Health Forum. They wore the official T-Shirt, "It's Up To Youth," which was later distributed to the students as well.*



*Dr. Bill Collins leads a workshop dealing with the dangers of steroid use among teens.*



*All work and no exercise makes for dull minds and bodies. Students were encouraged to include exercise into their healthy lifestyles.*



- 1) The production of a teen health forum on the state level.
- 2) The development of a "how-to" design to be adapted and utilized by county medical societies/auxiliaries for local adolescent health programs.

The MAG Board of Directors endorsed the plan and agreed to lend financial support and personal involvement when requested.

Over a year was spent in planning and designing the forum. Working with Carole Middlebrooks, Alcohol and Drug Abuse Education Coordinator for the University of Georgia, MAG, A-MAG, and the University formed a team and created the March 14, **"It's Up To Youth"** day.

**T**welve classroom-style workshops were planned to be conducted simultaneously three times during the progress of the day. Physicians, other professionals, and auxiliaries were contacted to serve as the faculty to conduct these workshops on the following teen problems: Sexual Involvement, Sexually Transmitted Diseases (STDs), AIDS, Alcohol, Drugs, Tobacco Use, Eating Disorders, Stress and Depression, Teen Suicide, Accidents and Head and Spinal Injuries, Date Rape, and Physical and Sexual Abuse.

Equal time was given to workshops on "Positive Addictions": Lasting Values, Building Self-esteem, Grooming, Decision-making Skills, Safe Exercise, Dangers of Steroid Use, Eating Smart, and Feeling Good About Oneself. The underlying message of all the workshops was "Reach for your potential; be the best you can be, and enjoy life while you are doing this."

Inspirational speakers and role models were selected, snacks and lunches were planned; the music and fun were scheduled; the Crawford W. Long Medical Auxiliary agreed to act as the hostess auxiliary from Athens; and the Tate Student Center of the University was procured. All that remained to be done was to contact the schools and give them the good news.



*Mrs. Jan Collins, President of A-MAG, enthusiastically welcomes the students to the Teen Health Forum at UGA.*

**L**etters were written to school principals. In the meantime, auxiliaries visited the schools to talk with instructors to furnish more information and to answer any questions they might have concerning the program.

The response was great! Scheduling and assignments were programmed into a computer. When all of the courses were filled, nearly

700 students and 100 instructors were accommodated and scheduled. There were still some schools wishing to come who had to be turned away.

Resource pamphlets and materials were gathered from the various health agencies and placed in packets for the students and instructors. An additional packet was compiled for the instructors use. It



included a copy of the MAG Adolescent Health video, "Scenarios" on making choices.

As the project took shape, enthusiasm and interest grew. Rick Stancil, Director of the Georgia Commission on Children and Youth, was sent a packet of information concerning the forum. The result was a beautiful proclamation signed by Governor Joe Frank Harris, designating March 14, 1989, "It's Up To Youth Day" and commending the Auxiliary to MAG for their efforts towards educating the young people of Georgia. (See p. 259.)

Finally the big day arrived! The stage was set, with the balloons floating gaily over the platform; the banner boldly proclaiming "It's Up To Youth" was in place; snacks were ready; the resource packets and programs were placed on the seats in the meeting hall; all were awaiting the arrival of the students. They began to arrive at 7:45 a.m. in small trickles, but as the 8:45 a.m. opening time neared, their numbers swelled. All of the registered schools were accounted for, plus three unregistered schools who appeared unannounced!

Dr. William C. Collins, Chairman of MAG's Board of Directors, was a dynamic Master of Ceremonies. He welcomed the participants, tried to recruit them all for admission to the University of Georgia, and then got about the business of the day.

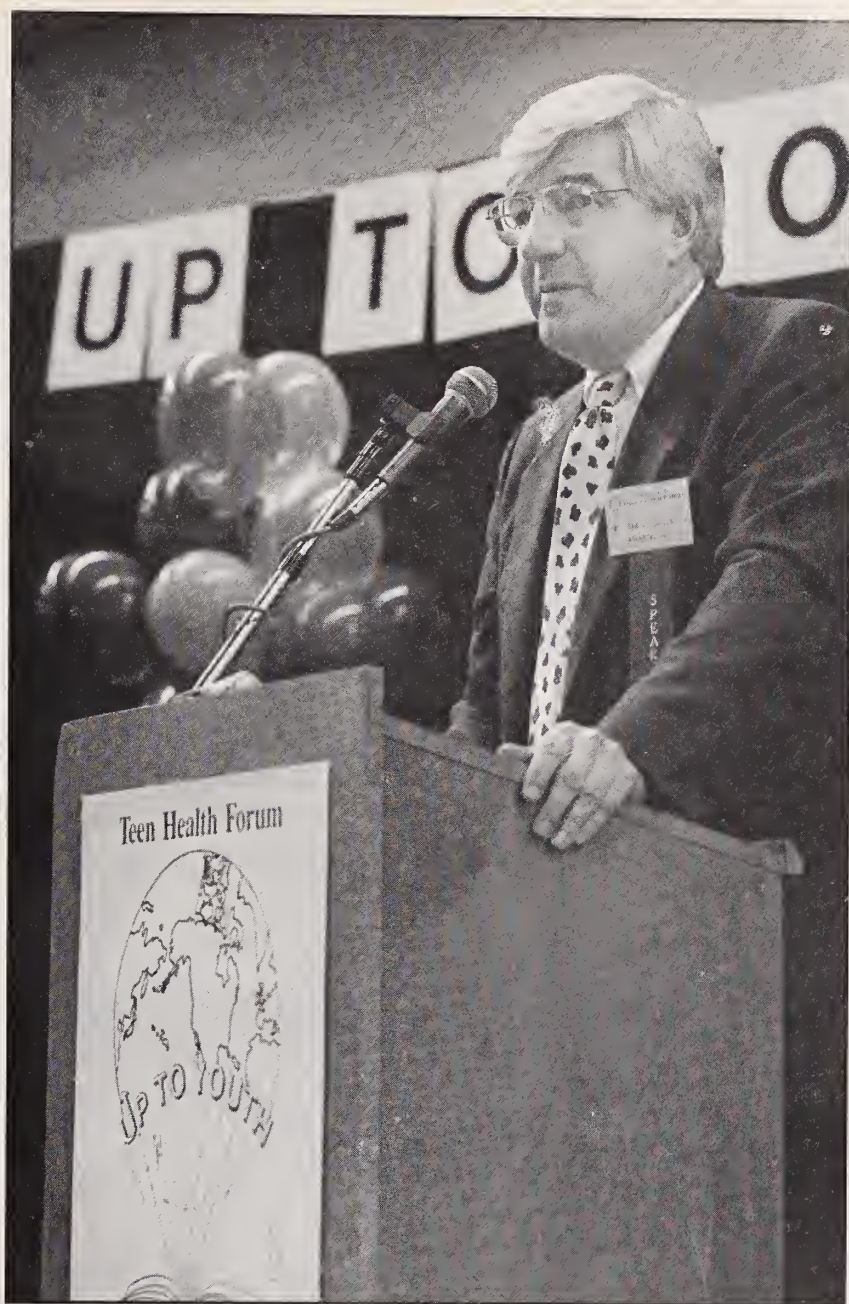
### Highlights

*Dr. Jack Menendez*, Immediate Past President of MAG, gave the Invocation and led the Pledge of Allegiance to the Flag.

*Dr. Joseph P. Bailey, Jr.*, President of MAG, read the Proclamation from the Governor and welcomed the guests.

*Mrs. Jan Collins*, President of the Auxiliary to the MAG, welcomed everyone and gave a brief history of how the program came to be.

*Alpha Delta Pi Sorority* ensemble, the Diamond Girls, sang songs such as "Wind Beneath My Wings" and "Out Here Alone."



*Dr. Bill Collins, Chairman of MAG's Board of Directors, was the dynamic Master of Ceremonies for the Teen Health Forum.*

*Ray Goff*, the new Head Football Coach for the University of Georgia, shared insights from his perspective. He expressed these tenets: "Everybody has pressures; life is not easy, it is tough — the biggest challenge you will ever face. You have to believe in yourself, have a dream, and believe in God. Remember, little eyes are looking up to you — if you ever have doubts about something, don't do it."

*Dr. Martin Moran*, a pediatrician with the Sandy Springs Pediatrics and Adolescent Medicine Clinic, was the Keynote Speaker. He told the students, "Living in America is the greatest thing on earth, because you have the luxury of making free choices . . . the choice you make is your destination; the way to achieve the goal or destination is the journey. The ingredients of your actions are dedication, determination, in-





(L-R) Barbara Tippins, of Atlanta, and Connie Menendez, of Macon, co-chaired the Teen Health Forum, "It's Up to Youth."

terest, concern, thoughtfulness. No nation can survive without its youth returning and remaining in school."

The breakout sessions were interspersed with other activities. *Toni Malcolm* of Creative Conditioning conducted a lively and vigorous aerobic exercising session . . . the young have real stamina. . . !

All ninth grade students, some 237, participated in a Health Risk Survey, dubbed just for the day, "HQ-Health Quotient," conducted by *Mrs. Marsha Wilkinson*, Project Director of the Department of Human Resources, Georgia Public Health Office. They seemed to enjoy the experience of receiving an immediate analysis of their health habits.

*The Derbies Pep Band*, a component of the U.G.A. Redcoat Band, conducted by Donnie Schofield, played a stirring medley of UGA "fight" songs and pep rally tunes while lunch was being consumed.



MAG Past President Jack Menendez points out the health consequences of smoking to a group of teens attending a workshop on that subject.



Frances Frazier, 1988 Miss Georgia, entertained the teens with songs and her wonderful sense of humor.



**W**ith dramatic drum rolls and musical interludes, four UGA college students presented their views on "Roles and Goals." The overall message running throughout each of their presentations was, "You must never lose sight of your goal; apply hard work, determination, and commitment to achieve it."

— *Theresa Edwards*, basketball player and Olympic Gold Medalist, "Playing basketball was my medium to meet the people of the world and learn about how they live. This is important to me because I come from a small town, Cairo, in south Georgia."

— *Kevin Brown*, a football player for UGA, "It was sort of a shock to me when I finished high school, and no college offered me a scholarship, but I wanted to play for the University so bad, I decided to come, and asked the coaches to let me try out." Kevin became a "walk on" for the University team and was awarded a "Battlefield Scholarship" by Coach Vince Dooly — practice and diligence paid off for him.

— *Wycliffe Loveless*, football player for the University, "I wanted to go to college to get a degree so

I could get a job; my degree — my goal. Playing football served a dual purpose — to get the degree, I had to play football and to play football, I had to keep up my grades. This motivated me to study harder." Wycliffe told the audience how he came back from four surgical procedures to play first string defensive end for the Georgia Bulldog football team.

— *Laura Wood*, Drum Major, University Redcoat Band, "Never think your role in life is insignificant; you can make a difference in so many ways. For a  
(Continued on p. 258)

## AMA Publishes Astonishing Facts About Adolescent Health

**I**N DECEMBER, 1986, the AMA published a *White Paper* which identified not ONE but FIVE areas of concern which contribute to the poor quality of adolescent health — Teen Sexuality/Pregnancy, Substance Abuse, Victimization, Psychologic Disorders/Suicide, and Violence and Trauma.

The following statistics are taken from the Executive Summary of the *White Paper*:

### Substance Abuse

- Two-thirds of American youth use an illicit drug before they finish high school, and one in five high school seniors smokes cigarettes daily.
- One in 16 high school seniors drinks alcoholic beverages daily, and 41% report that they have consumed five or more drinks on one occasion.

### Sexuality/Pregnancy

- Teenage mothers account for 46% of all births to unmarried women and a third of all abortions.
- Two-thirds of all sexually active adolescent girls do not routinely use birth control.

- Maternal mortality is 2.5 times higher in girls under the age of 15 than in women in their twenties.

### Victimization

- 24% of all fatalities and 41% of all serious injuries in reported cases of physical abuse involve persons age 12 to 17.
- 6% of all boys and 15% of girls experience sexual abuse by the age of 16.
- Half of all rape victims are less than 18 years old.
- 600,000 teenage girls and 300,000 boys work as prostitutes; their average age is 15.

### Psychologic Disorders/Suicide

- 5,000 persons under age 19 commit suicide each year, and 50,000 attempt it.
- Up to 10% of teenage girls suffer severe eating disorders such as anorexia.

### Violence/Trauma

- 80% of deaths in the 15- to 24-year-olds are secondary to accidents, suicides, and homicides.
- Adolescents are responsible for a third of all violent crimes.

# WORKSHOP SCHEDULE

COURSE

LOCATION

## SEXUALITY — LOVE IS A FOUR LETTER WORD

The desires to please the ones we love are powerful forces toward sexual intimacy.

101	"Let's Wait" - <i>Postponing Teenage Sexuality</i>		Room 134
	PRESENTERS	John E. Fowler, MD, Clayton; Margo McKinley, RN, Milledgeville	
	FACILITATOR	Mrs. Sally Darden, Hall Medical Society Auxiliary	
102	"Ignorance Isn't Bliss" - <i>Sexually Transmitted Diseases</i>		Room 142
	PRESENTER	Peter M. Payne, MD, Gynecologist, practicing at the University of Georgia Health Services, Athens	
	FACILITATOR	Mrs. Toni Shiver, Richmond Medical Society Auxiliary	
103	"Fight Fear With Facts" - <i>AIDS</i>		Room 137
	PRESENTERS	Thomas L. Lyons, MD, Obstetrician and Gynecologist, former University of Georgia football player and professional with the Denver Broncos. Team physician University of Georgia Women's Basketball, Athens;	
		Maureen Vandiver, AIDS Education Facilitator, Member Dekalb Medical Society Auxiliary	
	FACILITATOR	Mrs. Cherie Haun, Hall Medical Society Auxiliary	

## SUBSTANCE ABUSE DRUGS ARE A DRAG

The most dangerous drug for you is the one you choose to use. The ones you don't use can't hurt you.

111	"No Genie in the Bottle" - <i>Alcohol Abuse</i>		Room 143
	PRESENTER	Carole Middlebrooks, Coordinator of Alcohol and Drug Abuse, University Georgia	
	FACILITATOR	Mrs. Betty Dunn, Newton-Rockdale Medical Society Auxiliary	
112	"Blow Your House Down" - <i>Tobacco Abuse</i>		Room 144
	PRESENTER	Jack Menendez, MD, Surgery and Oncology, Immediate Past President of the Medical Association of Georgia, Macon	
	FACILITATOR	Mrs. Scotta Kitchens, Richmond Medical Society Auxiliary	
113	"Sniff, Snort, Pop, or Puff" - <i>There's No Magic Dragon - Drug Abuse</i>		Room 141
	PRESENTER	Martha Morrison, MD, Anchor Hospital, Atlanta	
	FACILITATOR	Mrs. Donna McLarty, Cobb Medical Society Auxiliary	

## ADOLESCENT ABUSE — TRUST BETRAYED

Parents and friends must not betray the faith and trust placed in them by teenagers.

121	"Broken Promises" - <i>Neglect, Physical, Emotional Abuse</i>		Room 145
	PRESENTER	Joy Maxey, MD, Pediatrician, Atlanta	
	FACILITATOR	Mrs. Jane Schwartz, Richmond Medical Society Auxiliary	
122	"Did You Really Score???" - <i>Date Rape</i>		Room 140
	PRESENTERS	University of Georgia SCOAR Chapter, Vernon Hall, Advisor, Athens	
	FACILITATOR	Mrs. Kelly McGinnis, Hall Medical Society Auxiliary	

## EMOTIONAL DISORDERS — THINGS ARE NEVER WHAT THEY SEEM

Life is composed of highs, middles, and lows. Dealing positively with lows is an essential part of growth.

131	"Is Anybody Listening" - <i>Teen Suicide</i>		Room 139
	PRESENTER	Timothy C. Knowles, Mental Health Assistant, Fulton County Emergency Mental Health Service, Atlanta	
	FACILITATOR	Mrs. Linda Gonzales, Member-At-Large, A-MAG	
132	"Lifestyle Out of Control" - <i>Eating Disorders</i>		Room 136
	PRESENTER	Barbara Nama, ASCW, Atlanta	
	FACILITATOR	Mrs. Betsy Fowler, Member-At-Large, A-MAG	
133	"Dumping the Doldrums" - <i>Depression and Stress</i>		Room 138
		Feeling lonely, bored, scared, frustrated, inadequate, rushed, anxious	
	PRESENTERS	Scott Snyder, MD, Psychiatrist, Athens; W. Theron McLarty, Jr., MD, Psychiatrist, Director, Ridgeview Institute, Smyrna	
	FACILITATOR	Mrs. Cheryl Gotay, Hall Medical Society Auxiliary	

## SAFETY - IT'S NO ACCIDENT

Automobile and other accidents are the number one cause of death in adolescents . . . they are preventable.

141	"All the King's Horses, All the King's Men" - <i>Accidents; Head and Spinal Injuries</i>		Room 135
	PRESENTERS	Robert E. Dicks, MD, Neurosurgeon, former University of Georgia football player, UGA Team Physician, Athens. Mrs. Lynn W. Dicks, Chairman, National Head and Spinal Cord Injury Prevention Program for Northeast Georgia, Crawford W. Long Medical Society Auxiliary, Athens;	
		Mr. James Aberson, Spinal Cord Injuries Special Speaker	
	FACILITATOR	Mrs. Lucy Baugh, Baldwin Medical Society Auxiliary	

201	"Let's Wait" - <i>Postponing Teenage Sexuality</i>	Same As 101	Room 134
202	"Ignorance Isn't Bliss" - <i>Sexually Transmitted Diseases</i>	Same As 102	Room 142
203	"Fight Fear With Facts" - <i>AIDS</i>	Same As 103	Room 137
211	"No Genie in the Bottle - <i>Alcohol Abuse</i>	Same As 111	Room 143
212	"Blow Your House Down" - <i>Tobacco Abuse</i>	Same As 112	Room 144
213	"Sniff, Snort, Pop, or Puff" - <i>There's No Magic Dragon - Drug Abuse</i>	Same As 113	Room 141
221	"Broken Promises" - <i>Neglect, Physical, Emotional Abuse</i>	Same As 121	Room 145
222	"Did You Really Score???" - <i>Date Rape</i>	Same As 122	Room 140
231	"Is Anybody Listening" - <i>Teen Suicide</i>	Same As 131	Room 139
232	"Lifestyle Out of Control" - <i>Eating Disorders</i>	Same As 132	Room 136
233	"Dumping the Doldrums" - <i>Depression and Stress</i>	Same As 133	Room 138
241	"All the King's Horses, All the King's Men" - <i>Accidents: Head, and Spinal Injuries</i>	Same As 141	Room 135



# WORKSHOP SCHEDULE

COURSE

LOCATION

## POSITIVE ADDICTIONS - A LUST FOR LIFE - "Reach Your Potential"

### FITNESS AND EXERCISE

Body Language - Your body tells you when you are overdoing a good thing.

301	"In Training" - Safe exercise, Hazards of Steroid Use	Room 134
PRESENTERS	William B. Mulherin, MD, Orthopedic Surgeon University of Georgia Bulldog Team Physician, Athens; Ron Elliott, MD, University of Georgia Bulldog Team Physician, Athens	
FACILITATOR	Mrs. Sally Darden	
302	"In Training II" - Same As Above	Room 139
PRESENTER	Frank Kelly, MD, Orthopedic Surgeon, Director of the Sports Medicine Center, Macon	
FACILITATOR	Mrs. Linda Gonzales	

### GROOMING, APPEARANCE, VALUES - LASTING IMPRESSIONS

303	"I Feel Pretty" Improving Self-image (Girls only)	Room 135
PRESENTERS	Chenault Hailey, MD, Dermatologist, Atlanta; Ms. Marianne Broadbear, President, Success Image and Young Sophisticate, Atlanta	
FACILITATOR	Mrs. Lucy Baugh	
304	"Be The Best You Can Be" - Developing Your Potential (For Girls Only)	Room 138
PRESENTERS	Mrs. Carol Grant, State Chairman Georgia Junior Miss Scholarship Program, Bibb Medical Society Auxiliary, Macon; Ms. Dana Brown, 1987 Georgia Junior Miss, Sophomore, University of Georgia; Ms. Diedre Ross - Cobb County Junior Miss 1988, Freshman, University of Georgia, Majorette; Ed Lewis, MD, Dermatologist, Athens	
FACILITATOR	Mrs. Cheryl Gotay	
305	"The Man In The Mirror" - Developing Individual Potential (Boys Only)	Room 136
PRESENTERS	Reverend Pat Seymour, Episcopal Minister, Athens; Mr. Dick Ferguson, Owner of Dick Ferguson's Men's Store, Athens; William C. Collins, MD, Orthopedic Surgeon, Atlanta	
FACILITATOR	Mrs. Betsy Fowler	
306	"The Man In The Mirror II" - Same As Above	Room 137
PRESENTERS	Rev. Jon Appleton, Minister, First Baptist Church, Athens; Dick Ferguson, Athens; William C. Collins, MD, Atlanta	
FACILITATOR	Mrs. Cherie Haun	

### PEER COUNSELING - ASKING FOR HELP IS A SIGN OF STRENGTH, NOT WEAKNESS "You've Got a Friend"

307	"Take My Hand" - Peer Counseling	Room 143
PRESENTERS	Mrs. Carole Middlebrooks, Coordinator, University of Georgia Graduate Students	
FACILITATOR	Mrs. Betty Dunn	

### DECISION-MAKING, SELF-ASSERTIVENESS, CHOICES "So What Are You Going to Do?"

308	Medical Association of Georgia Film for Adolescents - contains scenarios which present problems faced by teenagers and suggest methods of making wise decisions	Room 144
PRESENTER	Mark Hutto, MD, Psychiatrist, Atlanta	
FACILITATOR	Mrs. Scotta Kitchens	
309	Medical Association of Georgia Film for Adolescents - contains scenarios which present problems faced by teenagers and suggest methods of making wise decisions	Room 142
PRESENTER	Joy Maxey, MD, Pediatrician, Atlanta	
FACILITATOR	Mrs. Toni Shiver	
310	Medical Association of Georgia Film for Adolescents - contains scenarios which present problems faced by teenagers and suggest methods of making wise decisions	Room 141
PRESENTER	Martin Moran, MD, Pediatrician, Atlanta	
FACILITATOR	Mrs. Donna McLarty	
311	Medical Association of Georgia Film for Adolescents - contains scenarios which present problems faced by teenagers and suggest methods of making wise decisions	Room 140
PRESENTER	Steven Lee, MD, Psychiatrist, Medical Director of Charter Peachford Hospital, Atlanta	
FACILITATOR	Mrs. Kelly McGinnis	

### VOLUNTEERISM AND COMMUNITY SERVICES

312	"There's A Place For Me" - Community services to help others; to learn new skills; and to help prepare for future careers.	Room 145
PRESENTER	Mrs. Alice Asbell, Bibb Medical Society Auxiliary Mrs. Joyce Johnson, Bibb Medical Society Auxiliary	
FACILITATOR	Mrs. Jane Schwartz	

The following members of the Medical Association of Georgia staff were instrumental in making this day possible:

Mrs. Talitha Russell - Executive Director of the Auxiliary to the Medical Association of Georgia  
Mrs. Sherry Marsh - Director of Public Relations, Medical Association of Georgia  
Mr. Daniel Kohn - Computer Programmer, Medical Association of Georgia  
Ms. Maureen Franklin - Secretary, Medical Association of Georgia





*Ray Goff, head coach of the UGA Bulldogs, encouraged teens to follow traditional values as they faced their biggest challenge: life!*

feeling of real power, imagine that you are the Head Drum Major of a big college. Thousands of cheering fans have filled the stadium and are waiting; the team is ready; but nothing can happen until you give the signal to start playing the 'Star Spangled Banner.' That's real power!"

During the third session on Lasting Impressions — Positive Addictions, Joel Williams, Atlanta Falcon football player, encouraged the students to choose a goal, work hard to achieve it, keep fit, and stay away from drugs and alcohol. He fielded questions from the audience. He didn't think mandatory drug screening for NFL players would work. He didn't feel that this had worked in the past. He wouldn't make predictions about the coming football season, but said, "Of course, I would like to have a winning season and play in the Super Bowl."

*Frances Frazier, "Miss Georgia,"*



*Keynote speaker Martin Moran, M.D., a pediatrician in Atlanta, urged students to take advantage of their freedom of choice in America and stay in school.*

1988, wowed everyone with her singing and stage presence. She reiterated that everyone has a purpose in life. Commitment and discipline can help to reach any goal. When disappointments come, put aside your pride, recommit and persevere. The best advice her mother ever gave her was, "Frances, be the best YOU that you can be; you'd make a lousy somebody else."

Students and teachers received a T-shirt bearing the "It's Up To Youth" logo, designed by Mac Sims, a pre-med student from Valdosta State College.

Comments overheard from teachers and students alike were: "Awesome," "Wonderful program," "Well-planned, comprehensive and smoothly-run," "The best I have attended, wonderful." "When are you going to do this again?" . . . that was the general feeling of everyone. Comments from one physician speaker, "As I spoke, I noticed such bright, alert eyes looking at me, ea-

ger to hear each word I said." Others comments were, "I never saw such well-behaved children!"

**A** one-day event is not the cure-all for adolescent problems, but it is a beginning. The more truths and facts teens can receive, the more impact education will have, if not tomorrow, down the line. To make a real impact on the improvement of the health status of adolescents, experts tell us, everyone — the medical community, parents and families, schools, churches, the protection agencies, the social services, the media, the entertainment, and sports figures — everyone — must give the same strong message:

- Alcohol and drug abuse is destructive.
- Sexual involvement can result in STDs and unplanned pregnancies.
- Smoking and tobacco use is hazardous to your health.
- Out-of-control eating, bingeing, and purging can lead to health problems and sometimes death.
- Stress, depression, feelings of low self-worth are detrimental to a person's well-being and can result in suicide.

These messages need to be ongoing and stable — no mixed messages. Teens need quality time spent with caring adults.

Anchor Hospital, Ridgeview Hospital, Floyd-Polk-Chattooga Medical Auxiliary, Dr. and Mrs. James Kaufmann, Mrs. Carole Middlebrooks, and the Department of Student Affairs at UGA helped to underwrite some of the expenses of the event. Channel 5, WAGA TV (CBS), developed and showed a public service announcement to publicize the program and Channel 8 was there to film the entire day. Grateful appreciation has been expressed to each of these generous individuals and businesses.





BY THE GOVERNOR OF THE STATE OF GEORGIA

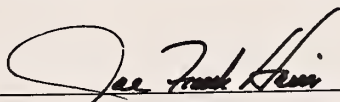
## A PROCLAMATION

### "IT'S UP TO YOUTH" DAY

- WHEREAS: Adolescents are the only segment of the United States population whose health status has not improved in the past 30 years; and
- WHEREAS: Both the morbidity and mortality rates for adolescents are 11 percent higher today than 20 years ago; and
- WHEREAS: There are over 300,000 teens ages 15 - 17 living in the State of Georgia, and it is vital that their health care needs are addressed; and
- WHEREAS: The Medical Association of Georgia and the Auxiliary to the Medical Association of Georgia are committed to improving the broad health care needs of these adolescents; and
- WHEREAS: The Auxiliary to the Medical Association of Georgia is sponsoring the "It's Up To Youth" Teen Health Forum as an effort to educate teens on the importance of maintaining their health and well-being; and
- WHEREAS: "It's Up To Youth" will offer over 600 high school students an opportunity to learn more about teenage pregnancy, substance abuse, the advantages of completing high school and having positive self-esteem, so that they can initiate school projects to address these types of problems among their peers; now
- THEREFORE: I, Joe Frank Harris, Governor of the State of Georgia, do hereby proclaim the day of March 14, 1989, as "IT'S UP TO YOUTH" DAY in Georgia in honor of this educational forum and in recognition of the Auxiliary to the Medical Association of Georgia for its efforts in providing for the health and well-being of our youth.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the Executive Department to be affixed. This 14th day of March 1989.



  
GOVERNOR

ATTEST

  
SENIOR EXECUTIVE ASSISTANT

**I**t's true that diabetes is no longer the grim diagnosis it once was. With every new discovery and innovation, the disease has less power over a patient's life. But the *really* good news is that now your patients with diabetes can get the full benefit of *all* these innovations at one

---

# **NOW YOU CAN GIVE YOUR PATIENTS THE *GOOD* NEWS ABOUT DIABETES.**

place—our state-of-the-art Diabetes Medical Center. The nursing staff, diabetic educator, dietitian, social worker, occupational therapist and physical therapist are specially trained to provide these innovative treatments. We concentrate on the lifestyle and livelihood of your patients—helping them take control through medication, self-monitoring, diet and exercise. We work with you to design the treatment and education

program that's right for each individual patient. We even offer our daily classes to outpatients with individual instruction as you require. And we keep you abreast of progress regularly.

The Diabetes Medical Center is supported by the full resources of DeKalb Medical Center. So you can count on cost-effective care and a highly-skilled professional staff.

The Diabetes Medical Center. The good news about diabetes. For patients and physicians. For more information, call 297-5397.



DeKalb Medical Center



# A-MAG's Legislative Performance

Cheryl Dennis

**F**OR THOSE WHO LIKE to be where the action is, zoom in your camera, turn up the lights and sound, and focus on LEGISLATION. It's thrilling and exciting to be interviewing Georgia's celebrity players at the Capitol, calling them on the phone, knowing the inside scoop, and being the first to call your friends with the hot headlines straight from the Capitol.

The A-MAG Legislative team got off to a fast start this year at an early summer meeting to make plans for an up-to-date Key Contact Program, a statewide networking plan, and most importantly, the A-MAG "Hotline" phone bank.

Our action and celebrity-minded president, Jan Collins, devoted a big part of the Winter Executive Board Meeting spotlight to legislation. The program was called "Some Like It Hot" and featured stars like Paul Shanor, Richard Greene, Joe T. Wood, Dr. Ralph Tillman, and Dr. Steven Marlowe. To top off the morning, Mrs. June Bratcher of the Texas Medical Association Auxiliary, spoke to us about auxiliaries influencing political campaigns.

By now, the clock was running out for 1988, but not before Anna Kathryn Brown of the Auxiliary to the Medical Association of Atlanta and her "Focus and Action" team could instigate an "X" Out A Day At The Capitol program. They hand delivered reminders about the importance of planning a day at the legislature to every physician in the metro Atlanta area.



*(L-R) Grace Walden, 1988-89 President-elect, A-MAG; Cheryl Dennis, Chairman of Legislation Committee; Governor Joe Frank Harris; Jan Collins, 1988-89 President of A-MAG.*

**W**ith the New Year came the opening of the 1989 Georgia General Assembly . . . the moment we'd be waiting for. The curtain is up, and our members go to work. Paul Shanor of MAG sends hot tips daily over the wires to our very own, politically savvy, Talitha Russell.

Cheryl Dennis (Mrs. Donald) is Chairman of A-MAG's Legislative Committee.

She then turns the story over to the Hotline leader and volunteers for action. The phone lines buzz as they contact physicians all over the state to keep them abreast of the issues. During the course of the Session, 63 volunteers staffed the phone bank for 126 hours. Besides calling physicians on key issues, auxiliaries signed up 58 physicians for the Physicians' Involvement Program (PIP).





*Chairman of the Auxiliary's Legislation Committee, Mrs. Cheryl Dennis, and Cobb County Senator Roy Barnes.*

On January 31, over 100 auxiliaries from all over Georgia came to Atlanta for a Day at The Capitol and a first hand look at government in action. It was a busy morning of photo sessions, hand shaking, and getting acquainted. Buses swished our politically minded ladies back to the Buckhead Ritz Carlton for lunch and a shopping potpourri.

Also in January, the legislative pack from the Hall County Auxiliary hosted a very successful party for their legislators at the home of Dr. & Mrs. Cosmos Hahn. From hearing Paul Shanor's account of the party, I'd say, "Hollywood, eat your heart out!"

It's not over yet, and this writer will reserve judgment until the final act. Tomorrow is just another day, and frankly, my dear, I do give a damn!

## COMPREHENSIVE CARE FOR YOUR PATIENT IS WITHIN REACH AT CPC PARKWOOD

With over 40 years of service to the Atlanta community, **CPC Parkwood Hospital** has a proud tradition of excellence in comprehensive patient care. Our progressive treatment programs are designed to meet the diverse needs of patients with difficult problems.

We offer adult, adolescent, and children's programs for psychiatric and chemical dependency treatment—and more. We specialize in programs for treating co-dependency, eating disorders, anxiety disorders, and the impaired professional.



An affiliate of Emory University, Parkwood is a 152-bed psychiatric and chemical dependency hospital.

When a patient requires both psychiatric and chemical dependency care, our staff works cooperatively to form an individualized treatment plan. Our intense aftercare programs foster ongoing recovery after discharge.

At Parkwood, our dedication to clinical excellence makes the difference. We don't just treat problems, we help people lead healthier lives.



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# From Around the State: Activities of County Auxiliaries

Allyce North

**P**ART OF THE JOY of volunteer work is the sharing of ideas and projects that have occupied auxiliaries around the state of Georgia each year. The reporting of these varies with different auxiliaries; some choose to highlight a specific project and others to give a general overview of the year's work. Following are highlights of some auxiliaries' activities; not all auxiliaries are represented.

**The Auxiliary to the Bibb County Medical Society** kicked off the '88-'89 year by participation in "Safety City," a program initiated by the American Red Cross to increase the safety awareness of 4 and 5-year-old children. For 10 days in June, 50 children came to a "miniature city" complete with streets, buildings, and traffic signals, where they learned to "drive" seat-belt equipped big wheels. They attended teaching sessions on water safety, bike safety, poison control, fire safety, bus safety, and others. Since accidents are the leading cause of death and injury to our children, it is hoped this experience will help to save the life of a child.

AMA-ERF had a most successful year. Gift wrap was sold and the

Holiday Sharing Card, through which our physicians donate to AMA-ERF, was designed by local auxilian, Gloria Smith. Our largest fundraiser was our benefit auction. Nearly \$10,000 was raised at this one event, bringing us to a total of \$14,000 for the year.

"Postponing Sexual Involvement — You Can Say No" is our health project being presented at private schools and other groups in Bibb County. It has been presented to the Bibb County Board of Education, and they have given a tentative yes to allow it in the public schools. Another health project is the promotion of education and awareness about AIDS. The auxiliary arranged for Dr. Harold Katner, a well-known AIDS specialist, to speak to the students at Southeast High School. AIDS information pamphlets will be distributed for the teens to read and share with their friends and families.

In October, Auxiliary members and volunteer physicians from the Bibb County Medical Society helped conduct the sixth annual Mini-Health Clinic at the Bibb County Sheriff's Department.

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Allyce North (Mrs. Alvin) is a member of the Auxiliary to the Medical Association of Atlanta. She served as guest editor of this special issue of the *Journal*.

Auxilians assisted with paper work, weighing, blood pressure, and collecting laboratory samples. Auxilians have also helped doctors from the Medical Society who volunteered to do athletic physicals at local high schools three times during the year.

Doctors' Day plans include placing flowers in local hospitals and churches and providing volunteers for the breast examinations at the annual Cherry Blossom Health Fair. We are promoting mammograms and breast exams within our auxiliary by having an RN from Focal Pointe Women speak at our February meeting. And we are distributing American Cancer Society pamphlets to local physicians for enclosure in their monthly billing. Our auxiliary is continuing to promote better health care in our community.

**The Auxiliary to the Cobb County Medical Society** focused this year on three projects for the community health of Cobb County. In the fall we had an Auction which benefitted "The Open Gate," a child abuse shelter in Cobb. Our members and guests were generous in their donations, and it was a fun social "togetherness" for our auxiliary.



Then our physicians and auxiliary members participated in a blood drive in March. This was an important event for our county, helping to project to the community that physicians care. Later in the year, we presented an "Alcohol and Women" program with Kennesaw College, The Junior League, and the Y.W.C.A. This program addressed not only alcoholism, but focused on early pregnancy and early onset of drinking due to teen peer pressure. The Cobb Auxiliary feels that they have made a significant contribution in the health and education of their community.

**I**t is recognized that the number one health risk to children in the United States is preventable accidents. That is the leading killer of children under 14. A total of 8,000 children died last year from preventable accidents. Approximately 50,000 are permanently disabled by accidents that could have been avoided. Twelve million were hurt badly enough to need medical attention. If it were a disease killing our young, we would spend millions on research . . . but it should actually cost us nothing . . . we just need to be more careful and aware of the causes of these accidents. Twenty years ago, **DeKalb Medical Auxiliary** launched a campaign to do just that. They built a "House of Hazards" that depicted the everyday dangers in a home and housed the display in the County Health Department for hundreds of children and parents to view from year to year. It was a wonderful project . . . but alas . . . all things age and everything needs a "new look" as time passes. This year the DeKalb Auxiliary has taken on the job of updating and "facelifting" this wonderful project that has been too beneficial to too many people to fall by the wayside. We like what we have done. Come see us. We're always on display at the DeKalb Health Department.



*Carolyn Moon, President of the DeKalb County Medical Auxiliary, shown here painting the House of Hazards located in the DeKalb County Health Department.*

**T**he **Glynn County Medical Auxiliary** sponsored an AIDS Information and Instruction Seminar held on February 28, 1989. Co-sponsors were the Glynn County Medical Society and the Glynn-Brunswick Memorial Hospital. Speakers for the seminar were an eclectic group representing the American Red Cross, local and state health agencies, and the United States Navy. The objective of the seminar was that through lecture, discussion, and audio-visual presentations, the participants would gain information and perspective on the AIDS crisis and would become a resource for AIDS education programs in their own workplaces. The target audience for this project included representatives from the police department, the fire department, emergency medical services, Brunswick Nursing School, Glynn County School District, and local businesses.

**I**n an effort to honor its physicians, both past and present, the **Hall County Medical Society Auxiliary** chose an interesting and unique project this year. In conjunction with the

community-based Green Street Station Museum, auxiliary members began to gather information relating to the history of medicine in Hall County and Northeast Georgia. Medical history in this geographic area is rich in substance: healing springs, invention of the first orthopedic table, discovery of anesthetic agents, and so on. But this history is young enough to be within reach of the memories of the area's oldest retiring physicians.

Auxiliary members are thus gathering this information via oral histories these senior medical professionals are able to provide. Members are collecting and classifying old medical instruments and texts. And with the assistance of the professionals at the museum, auxiliary members are refurbishing the current medical history display as well as planning a new display relating to medical practice in the area around 1800. Hall County Auxilians are enjoying the interest and support of both their medical spouses and of the community. It is hoped that these efforts will result not only in a written history of medicine in the area and an eye-catching display at the Museum, but also an increased





*Members of the Hall County Medical Auxiliary, after completion of the first phase of the Medical Room Restoration, Green St. Station. Shown back row, L to R: Julia Clebsch, director of Green St. Station; Robbie McCormas, president-elect; Cheryl Gotay, immediate past-president. Front row: July Range and Kate Zoercher.*



*Mrs. Irene Hobby, recipient of A-MAA's first Distinguished Service Award, and her husband, Dr. Lovic Hobby.*

request. At the President's Ball, awards were presented. The recipient of this year's A-MAA first Distinguished Service Award was presented to Irene Hobby (Mrs. A. Worth). Her membership and involvement in the auxiliary has spanned over 40 years. She is a past A-MAA president and past state president.

spirit of cooperation and respect between the people of Northeast Georgia and their health providers.

**T**he 1988-1989 year of the **Auxiliary to the Medical Association of Atlanta** marked the 65th anniversary since its first organizational meeting on November 20, 1923. To celebrate this event, a champagne tea was held to honor all past-presidents and to introduce all new members. Not only was this a year of celebration; it was also a year of support of A-MAA member and State Auxiliary President, Jan Collins.

The Medical Association of Atlanta requested that three joint meetings be scheduled this year. Feeling that the MAA and A-MAA were working closer together, it was an honor to comply with this



*Auxiliary to the Medical Association of Atlanta's 65th birthday celebration honored Past-Presidents.*





Kimberly Dyer, A-MAA's Legislative Chairman, delivering "X-Out A Day For The Capitol" calendar.

Since Atlanta is the capital city, legislation is a special responsibility to the A-MAA. A new legislative project was developed and instigated by the board. A team of members delivered nearly one thousand "X Out A Day For The Capitol Calendars" to physicians throughout the metro-area of Atlanta. The purpose was to encourage the physician to mark time off for a visit to the Capitol during the months that the Georgia General Assembly was in session. A special legislative meeting with MAA entitled, "Warning: The Presidential Election May Be Hazardous To Your Practice" was held and the Phone-Bank took special attention from A-MAA.

During the entire month of April, "Gourmet Gatherings" was held. This project benefits "Atlanta's Medical Heritage." Between 1985 and 1988, nearly \$20,000 has been raised to finance some of the restoration of the Academy of Medicine. For this, homes of physicians and their spouses were opened for dinner parties to the medical community, creating an atmosphere of festivity and friendship.

Membership is an area of great

concern to the A-MAA board. Because of the size and diversity of Atlanta's medical community, this auxiliary has a special challenge to interest new members and to stimulate its seasoned members. A-MAA President-Elect, Tish Lanier, initiated a "Sponsorship" program for new members. Each new member was assigned to an experienced member with a 2-year responsibility of introducing this member to the auxiliary and its activities.

Health projects were AIDS education; the puppet shows, "Drugs Are A Drag" and "It's O.K. to Tell"; organ procurement; and the state health project, "It's Up To Youth." We joined the Council for Children, Inc., an organization supporting education on child injury. Auxiliary member, Cherry Baumgartner, wrote a play to be used by this council.

A traditional "Doctors' Day" luncheon was held at the Academy of Medicine honoring all retired physicians. It was arranged to have Atlanta Mayor Andrew Young issue a proclamation designating March 30 as Doctors' Day in Atlanta. Posters were sent to metro hospitals.

This year's theme was "Focus and Action." The board's main focus was on legislation and membership. Successful action was taken to improve involvement in both these areas.

**T**he major health project for the **Auxiliary to the Muscogee County Medical Society** was aimed at adolescents. The Society purchased an AIDS film and tape, "AIDS: Everything You Should Know," featuring Whoopi Goldberg and Alexandra M. Levine, M.D. An auxiliary member took the film to each of our local high schools where it was seen by all 10th, 11th, and 12th graders — approximately 15,000 students. Medical society members were present after the film to answer students' questions. Mrs. James Sullivan, Health Projects chairman, is trying to schedule the film in the entire 19 county

areas served by our local health department. The other part of this large project was to staff the health department's teen pregnancy clinic. An auxiliary volunteer showed a tape on some aspect of maternal health or infant care and initiated a discussion on what the girls learned from the tape. This clinic sees approximately 20 girls each week, and there were 19 Auxilians who worked on this effort to educate the teenagers of Muscogee County. In addition, the auxiliary expanded our miscarriage booklet program to include all outpatients as well as inpatients at the three hospitals in Columbus; brought Dr. Iris Bolton, a teen suicide expert, to speak to the community; and helped to fund and staff the local AIDS conference.

**I**n November, the **Auxiliary to the Richmond County Medical Society** participated in the Richmond County Health and Safety Fair. The program was entitled "Kids in Charge" and was presented to 2500 second grade students. This program included three stations:

Station 1: *Coping With Fear When Alone*, in which Auxiliary members discussed things to help students cope with fear. They played a "Danger Game" in which students decided if situations involved Real Danger, Possible Danger, or No Danger.

Station 2: *Personal Safety*, in which members conducted several role-playing activities with students involving phone skills, home safety, and answering the door when alone.

Station 3: *Child Abuse Puppet Show*, in which members presented the child abuse puppet show "It's Okay to Tell" which demonstrates four specific types of child abuse.

Additionally, auxiliary members prepared a booklet for the students to take home with them. The booklet included activities pertinent to the presentations and will serve as a review of the topics discussed.



In addition to our Smoking and Pregnancy Awareness programs, the **Walker-Catoosa-Dade Medical Auxiliary** concentrated on teenage pregnancy with the help of video cassettes and audio cassettes. Posters have been ordered from the American College of Obstetricians and Gynecologists to be distributed through our counties' Health Departments, public schools, and private physicians. The cassettes were aired on the WQCH radio station and the Telescript Cable Television Company.

**“Buckle Up — We Love You”** has been the theme of the **Whitfield-Murray Medical Auxiliary** for the 88-89 school year. Every month a new mini-project has been undertaken. Some projects have been small, and some are extensive, but the varied projects have complemented the varied interests of our auxiliaries and the varied needs of the community. Some of the projects have been riding city school buses (half of which have seat belts) and encouraging students to buckle up; operating a child safety restraint booth at a Teen Health Fair; presenting a safety belt awareness program to all of the kindergarten students in Whitfield and Murray Counties; giving T-shirts to all newborns in the counties stating “I’m a Born Buckler;” taking cards to all florists and tuxedo rental facilities to be enclosed in corsages and tuxedos at Prom and Ball time to encourage teens not to drink and drive and to wear safety belts; donating 12 infant car seats to an organization assisting teen mothers; manning a safety belt booth during a Children’s Health Fair in the mall; producing a video to be shown to the new mothers in the birthing center at



*Whitfield-Murray auxiliary presenting Safety Belt Awareness Program to one class of kindergartners.*

Hamilton Medical Center; and sponsoring participation of the third and fourth graders in a safety belt poster contest. The auxiliary feels that if one life is saved due to our efforts, “Buckle Up — We Love You” will have been a success.

And so the curtain falls on the final act of this whirlwind tour around the state to get a partial glimpse of what these dynamic, committed auxiliaries have contributed to their communities. They deserve rave reviews.

### **The Doctor's Wife**

She's always there —  
— THE DOCTOR'S WIFE  
The trials of life  
to see us through  
The encouragement of faith  
to share medicine, too  
The cheerful manner and  
winning smile  
The loyalty and devotion  
making life's journey worthwhile.

She's always there —  
— THE DOCTOR'S WIFE  
To chauffeur the children  
and guide their ways  
To cook and sew, a loving  
home to make  
To volunteer for community needs  
and enduring projects undertake  
To understand the urgency of  
medical calls that cannot wait.

She's always there —  
— THE DOCTOR'S WIFE  
An auxiliary member to promote  
our cause and image make  
A strong supporter for  
medicine's wonderful heritage sake  
A devoted mate and girl Friday, too  
a special person to share our life  
The one we love —  
— THE DOCTOR'S WIFE

*William D. Crawley, M.D.*

---

*Dr. William D. Crawley has practiced obstetrics and gynecology in Rossville, Georgia, for 30 years. He wrote this poem for his wife, Laura, for their 32nd wedding anniversary. Other than poetry, his hobbies include folk art and decorative painting.*

*Editor's note: We know that the M.D.'s spouse is no longer exclusively female. But this is one physician's tribute to the traditional Doctor's Wife.*



# Team Efforts — Medical Societies and Auxiliaries

## *"The Jan & Joe Show"*

Jan Collins

**L**AST SUMMER, I received a call from Hazel Lewis, Executive Director of the AMA Auxiliary. "Mrs. Collins," she said, "Georgia is recognized nationally as an auxiliary that has a very good and effective working relationship with its state medical society. Would you and [MAG President] Dr. Bailey be willing to present a 'How To' program to other auxiliaries around the country at our AMA Auxiliary Leadership Confluence?"

This is how Dr. Joe Bailey and I came to present the program "Team Efforts — Medical Societies and Auxiliaries" in Chicago in October, 1988, and in January, 1989. During our research for this program, we learned some interesting things.

In order to collect background material for the presentation, we brought together some of the past state auxiliary presidents, along with Talitha Russell, Executive Director of the Auxiliary to the Medical Association of Georgia. I was not surprised to learn that the joint efforts of MAG and its Auxiliary went back many years, and each year the team concept had increased and strengthened.

Interestingly, the first "Joint Project" we could discover began in 1929 with Dr. William R. Dancy



*Auxiliary President Jan Collins and MAG President Dr. Joe Bailey represented Georgia at the AMA Auxiliary Leadership Confluence in Chicago last October and discussed how their two groups had learned to work as a team.*

of Savannah, President-Elect of MAG. He asked the state auxiliary, which was then 5 years old, to begin an educational loan fund to help medical students. This loan was never intended to fund students' education, but simply to "help them over the rough spots." Originally, it was primarily intended to aid the children of physicians. Each auxiliary was

asked to pledge at least \$1.00 per member. The William R. Dancy, M.D., Student Loan Fund is still going strong today. Help from this fund is available to any student meeting the criteria from each of the four medical schools in Georgia.

Other joint MAG/A-MAG Projects are listed below:

**"Operation Care" — 1983-1984:** Computerized phone

Mrs. Collins is the 1988-89 President of the Auxiliary to MAG



referral service designed to provide for the medical needs of unemployed Georgians who had lost their health care benefits. MAG provided the participating physicians and handled all administrative and financial responsibilities. The Auxiliary handled the entire phone referral service.

**"It's Okay To Tell" — 1984-1985:** A public service campaign, developed in cooperation with the Georgia Governor's Office, aimed at increasing reporting of child abuse and reducing the incidents of abuse. MAG and the Georgia Department of Human Resources handled the administrative, financial and public relations aspects of this campaign. The Auxiliary handled the school component of the program which entailed getting a child abuse puppet show into as many Georgia elementary schools as possible.

**Tort Reform — 1985-1987:** A grass roots support for Tort Reform legislation. Prior to and during the Legislative Session, MAG and the Auxiliary manned phones for votes on specific bills, spoke to civic clubs on the need for tort reform, lobbied legislators, and marched on the Capitol to increase awareness of the inequities of the tort system.

**"You Can Say No" — 1986-1987:** A public service campaign aimed at increasing awareness of and reducing the incidence of early teenage pregnancy. MAG developed all media materials and hosted a press conference to kick off the campaign. The Auxiliary was, once again, responsible for the school aspect of the campaign. Auxiliary members underwent extensive training to become teen service counselors, enabling them to show a teen pregnancy video and initiate discussion among students.

**"AIDS: Fighting Fear with Facts" — 1987-1988:** A comprehensive education effort with participation from MAG's Communication and Legislative

Divisions as well as the Auxiliary. The Auxiliary assisted in every phase of this effort, including speaking at civic club meetings and health forums.

**"A Healthy Lifestyle: A Prescription for Life" — 1988:** A campaign to promote healthier lifestyles among Georgians and to confirm physicians as experts in promoting accurate health information. Auxilians promoted this project throughout the state.

**"It's Up To Youth" — 1989:** A highly successful teen health forum at the University of Georgia (UGA) was planned, directed, and produced by the Auxiliary. The program's focus was to help teenagers raise their awareness about such health issues as alcohol and drug abuse, sexuality, self-esteem, and safety. MAG, assisted by UGA and other contributions from the community, funded the project. Many physicians and auxilians served on the program. A complete report of "It's Up To Youth" can be found elsewhere in this issue of the *Journal*.

In addition to joint health projects, the Auxiliary plays a key role in MAG's legislative activities. The Auxiliary's Legislative Committee works year-round with MAG's legislative team. Examples are:

- 1) The Auxiliary produces lobbying workshops on the state level and encourages legislative education and activity on the county level.
- 2) The Auxiliary staffs a "Hot Line" phone bank at MAG headquarters during the legislative session.
- 3) Each county auxiliary is urged to form its own "telephone tree" so that information from MAG concerning critical medical legislation can spread to physicians' families throughout the state in a matter of hours.
- 4) The Auxiliary hosts a statewide visit to the Capitol — this year called "Some Like It Hot."
- 5) The Auxiliary emphasizes the statewide key-contact program,

whereby a physician's family "adopts" a legislator and becomes a medical contact for that legislator.

- 6) The Auxiliary promotes the S.I.P. Program (Spouse Involvement Program) that encourages county auxilians to visit the Capitol and contact their legislators.

Auxilians presently serve on 13 MAG standing committees. On the GaMPAC Board of Directors, there is one Auxiliary member from each congressional district. There is also an Auxiliary member on the Executive Committee to GaMPAC.

As we presented this program on "Team Efforts," Dr. Bailey and I stressed the need for close and frequent communication between the medical society and its auxiliary. In our state, the Auxiliary president reports quarterly to the medical society's Board of Directors. She reports annually to the MAG House of Delegates. The MAG president brings greetings to the Auxiliary's Summer and Winter Executive Board Meetings, to the Annual Meeting, and to the Post-Convention Board Meeting.

We feel that joint social functions are also extremely important in establishing a sense of partnership between the Medical Society and the Auxiliary. For the second year now, there is a joint reception at the Annual Session honoring outgoing MAG and Auxiliary presidents.

It was truly an honor for "The Jan and Joe Show" to represent Georgia as an example of what can be accomplished when a medical society and auxiliary work together with mutual admiration, mutual support, and mutual trust. The team efforts of the Medical Association of Georgia and its Auxiliary have given us the opportunity to blend our resources in work and in fellowship to meet the problems, the challenges, and the opportunities facing medicine today.



# "Brother, Can You Spare a Dime?"

*William R. Dancy, M.D., Student Loan Fund*

Jana Hill

**I**N 1929, the Student Education Fund was begun when MAG President-Elect Dr. William R. Dancy of Savannah approached the Auxiliary about starting such a fund. At that time, many doctors in the state were unable to pay the tuition for their sons to attend medical school, and the loan fund was begun primarily to help them complete their medical education. In 1956, the name was officially changed to the William R. Dancy, M.D., Student Loan Fund. And in 1966, Mrs. Dancy made a donation of \$4,000 to the fund.

The loan fund was reorganized

in 1986, and for a while, no new loans were made. It is hoped that the loan fund will be reactivated in the spring of 1989.

**I**n the meantime, recent recipients of the loan have contributed to repay their obligation to the fund. Other monies are generated through the county auxiliaries, who pay at least a dollar per member each year.

Jana Hill (Mrs. Robert S.) is state chairman of the William R. Dancy, M.D., Student Loan Fund, a past president of the Richmond County Auxiliary, and is the nominated President-elect of the Auxiliary to the Medical Association of Georgia.

The eligibility requirements are that the student be a resident of Georgia, attending a Georgia medical school; must have an acceptable scholastic rating; is encouraged to remain in Georgia; and must submit three references, including a letter proving acceptance to a Georgia medical school. The loan has a yearly interest rate and becomes interest bearing. Payments begin 1 year from the date of graduation.

For further information, please contact: Executive Director, A-MAG, 938 Peachtree St., Atlanta, GA 30309.

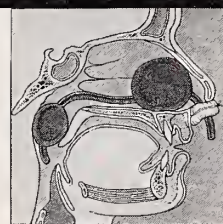
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### CUMULATIVE INDEX

# Peachtree Parliamentarians:

## Two Auxilians Ready For The Question

Mary Ann Marks

**W**HEN JULIA VON HAAM, known to almost everyone as Julie, attended the Auxiliary to the AMA Convention in Chicago as a delegate from Georgia in 1980, she was intrigued but a bit puzzled with one order of business. The Bylaws of the Auxiliary were amended to use a professional parliamentarian rather than one elected from the membership. A "professional" parliamentarian? What distinguishes one as a professional parliamentarian? It all sounded terribly procedural to her.

"When I returned to Atlanta" said Julie, "I contacted the person I considered most authoritative in this field — Ethel Davis. Ethel put me in touch with Edna Lewis and Ruth Esche, and I began studying with them." Thus, she had taken the first step on the road to becoming a "professional parliamentarian."

**M**ary Lou Stephens, a Cobb County auxilian, followed a more didactic approach. Being involved in a number of organizations, she became increasingly dissatisfied with the amount of time devoted to unstructured meetings. She knew there was a better, more orderly way to conduct business, and she wanted to know about it. She began a course of study which would eventually enable her to teach others about parliamentary procedure and organizational management.



*(L to R) Julie Von Haam and Mary Lou Stephens, co-founders of Peachtree Parliamentarians.*

Mary Lou enrolled in a workshop that Ruth Esche was teaching for Junior League members. From that first workshop, she knew she was on her way to becoming a "professional parliamentarian." When she pursued more advanced classes, Julie was a fellow classmate. They became great friends and eventually partners and founders of Peachtree Parliamentarians.

Mary Ann (Mrs. Thomas) Marks is Program Development Chairman of the Auxiliary to the MAG.

Mary Lou and Julie are accredited by the National Association of Parliamentarians which has about 4,000 members. Membership is attained by passing a written examination on basic parliamentary procedure. To become registered, one must pass another 5-hour exam which is very comprehensive and difficult — only 20% of the applicants passed the exam when Julie and Mary Lou took it in 1984. There are approximately 900 registered





*MAG members attend a workshop conducted by Peachtree Parliamentarians and learn the essentials of conducting efficient and effective meetings. The workshop was held in conjunction with MAG's Leadership Conference last February.*

parliamentarians in the National Association. A further credential may be attained by successfully completing a course to become a Professional Registered Parliamentarian. They attained this status in 1985, and they are both now on the faculty for this course.

Nationally, there are between 300-350 Professional Registered Parliamentarians who actively work as consultants to organizations. In the Atlanta area, there are only three, Julie, Mary Lou, and their teacher, Ruth Esche.

**S**o, what do they really do? More than you might imagine! In a sophisticated, well-organized and very well-written brochure, which they designed and wrote, Mary Lou and Julie described many of the services which they offer. In addition to the brochure, they coauthored *Parliamentary Procedure for Leaders* which they use in teaching. The revised edition of this book is currently being printed.

If you are thinking these are two "no-nonsense, all-work-and-no-play" type women, then think again. They are involved with families, schools, social, civic and community organizations, volunteer opportunities, and politics. When I asked them about hobbies, Mary Lou laughed and said that she felt hobbies should go along with your position in life at that particular time. She confessed that she had

had a variety of hobbies over the years, but that most of her current ones were fairly challenging, i.e., snorkling, snow skiing, and mastering her computer. Her one exception is reading, which is an ongoing pleasure.

Julie lists among her hobbies tennis, snow skiing, reading, bridge, and collecting hedgehogs. (A small collection — only about 30, she says!)

They feel it is an interesting coincidence that they both are physicians' wives, both former nurses, and each have 17-year-old sons. Mary Lou has an older son at Florida Institute of Technology; Julie has a son at University of California-Berkeley and a daughter at Williams College. Each gave their physician husbands high marks for being very supportive and involved in their new careers (both husbands have taken their workshop more than once).

**W**hile there are many similarities among these partners, there are also differences which, according to Mary Lou, really surface when they are team teaching. Julie tends to be very technical and deliberate, very patient and thorough, while Mary Lou's style is more fast moving and flamboyant with a more logical than technical approach. In their teaching they easily interrupt each other, disagree with each other, and most importantly,

they laugh at and with each other, all of which serves to underscore their teaching that there are alternate solutions to problems.

Mary Lou presently serves as President of the Georgia Association of Parliamentarians. Julie is the immediate Past President of this organization. Both are members of the Cobb County and Atlanta Chambers of Commerce and the Atlanta Convention and Visitors Bureau. Mary Lou is a member of Leadership Cobb, while Julie is a member of Forward Atlanta. Julie is a past president of the Cobb County League of Women Voters, the Auxiliary to the Medical Association of Atlanta, and the only woman ever to serve as president of the Cochise Riverview Swim and Tennis Club. Mary Lou has recently been appointed to serve as Advisor to the Cobb County Commission, is a sustaining member of the Cobb/Marietta Junior League, and an active member of the Auxiliary to the Cobb County Medical Association.

To their credit, their list of satisfied clients is long and impressive and represents a wide range of civic, cultural, educational, medical, and business organizations. They anticipate a busy Spring and each will be attending the Medical Association of Georgia's Annual Meeting — Julie will serve as parliamentarian for the Auxiliary and Mary Lou as parliamentarian for the MAG House of Delegates.



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# Auxilians in Public Service

*"I Need Your Vote . . ."*

Allyce North

**A**UXILIANS THROUGH THE YEARS traditionally have been involved in community affairs on many levels. But more and more auxiliarians are using their talents and resources to be involved in their communities in elected capacities. They see a need and offer to the public their energy and expertise in varied fields. It is exciting to see them recognized on a stage larger than the auxiliary. Certainly this is not a complete cast of auxiliary/politicians; but it is hoped that by highlighting these examples it will stimulate potential school board members, county commissioners, city council members, mayors, etc.

**D**elores D. Shields is a member of the Auxiliary to the Bibb County Medical Society. Dee is married to Dr. Joseph D. Shields, III, an internist, and the mother of four children. Since moving to Macon in 1969, Dee has strived to make a difference in the community. Her impact has indeed been felt as she has worked to improve the quality of life for all Macon citizens.

Dee became an active community volunteer and served on the



*Delores D. Shields*

Allyce North (Mrs. Alvin) is a member of the Auxiliary of the Medical Association of Atlanta. She served as guest editor of this special issue of the *Journal*.

board of directors of the Macon Heritage Foundation, Macon Arts Alliance, and the United Way of Macon. She served for 2 years as president of the League of Women Voters. This brought her recognition for her interest in the city's economic development problems, and she was appointed to the Macon-Bibb County Urban Development Authority for 8 years. She was elected vice-chairman of that body and has been a leader in the Downtown Macon revitalization work. She was appointed to the Macon-Bibb County Planning and Zoning Commission. There, she emerged as a defender of strong neighborhoods, spearheading the Northside Development Plan, which is now a model for neighborhood plans throughout Macon.

With this background, Dee then ran for the Macon City Council, campaigning on the belief that an individual can make a difference and that a city council member should listen intently to all voices and views. She has now won several terms as City Council member and has proved herself to be an important part of good government in

Macon. She has been on the Macon-Bibb County Water and Sewerage Authority and is Chairman of the Macon Fire and Police Pension Board. She is also chairman of the Human Resources and Community Development Policy Committee of the Georgia Municipal Association. She is a member of the Career Women's Network and the National League of Cities.

In addition to her community service, Dee also feels a commitment to medicine. She chaired the Citizen's Advisory Committee for the establishment of the Mercer University School of Medicine. And through the years she has been a faithful and active member of her auxiliary, serving in various capacities. Dee says, "I enjoy volunteer work and enjoy working in the public sector. I encourage other doctors' wives to run for public office. It is very gratifying to be able to say I was there, and I made a difference."

**C**onnie Meier is another auxilian who feels very strongly that her community offered such an opportunity for nurturing and educating her family that she needed to give something back. She and her late husband John raised their six children in Albany, and now that they are grown she feels she has much to offer her community. She enhanced her leadership skills as president of the Dougherty County Auxiliary and as president of the Auxiliary to the Medical Association of Georgia. Now she is 2 years into a 4-year term on the Dougherty County Commission. She is the first woman to be elected to office in Dougherty County. She is chairman of the local Health and Human Services board and on the state and national committee of this organization. She is a trustee for the local library, for Darton College, and for the Museum of Art. This year she is the honorary chairman of the local Easter Seals Telethon.

Connie still has time for her family, especially her eight grandchildren. One of her sons is an orthopedic resident, one a lawyer, and a son-in-law is in the insurance

business, so she says they spend a lot of time talking about the weather. But you know from talking to Connie that everything she says and does is to contribute to making Dougherty County a better place to live, work, and grow.



*Jane Howington*

**J**ane Howington is an active member of the Auxiliary to the Richmond County Medical Society and has served as the auxiliary's legislative chairman. Jane is the mother of two boys and has always been interested in education and has served as president of her children's P.T.A. But she soon learned that the school board meetings were where the decisions were really made. After attending a Leadership Georgia meeting, she decided to become involved in politics and entered the Columbia County School Board race. Not only was she the first woman to become elected to the school board, she also was the first woman to become chairman of the school board. While she was chairman, the board spearheaded and passed a 12.5 million bond referendum for new schools. She has served 4 years on the board and was re-elected this past fall for another term. Jane thinks Columbia county is the second fastest grow-

ing county in Georgia because of the quality of the schools. Hers is a story of one mother who truly did what she could do.

**E**thel Boyle and her husband Stephen, a general surgeon, live in Rockdale County where they are raising their three children. Ethel is a former schoolteacher who retired to raise a family. She has a deep belief in public schools and has now been twice elected to the Rockdale County School Board, serving as vice-chairman, then as chairman of that board, the first woman to be so named.

Before running for public office, Ethel had served on the Rockdale Recreation Commission. She was a charter member of the Newton-Rockdale Auxiliary and served three terms as treasurer and remains an active auxilian. She encourages all auxiliarians to be active in their communities in all phases of government and volunteer work.

**B**etsy Fowler and her husband John have lived in Clayton in Rabun County for 25 years. Since there is no organized auxiliary there, Betsy for years has belonged to the state and national auxiliaries as a member-at-large because she felt it was important to be a member of a support group for medicine. She



*Betsy Fowler*



is a former schoolteacher and now a dietician, being a dietary consultant at Rabun County Hospital and an Eating Disorders Dietary Consultant at Woodridge Hospital in Clayton.

Betsy first perceived that a community reflects proportionally its educational system. She waited until her two boys had graduated from the Rabun County public schools so there would be no perception of wanting something for self, then she ran for the School Board. She recognized what her boys had received and wanted to give something back to the next generation of school children. She campaigned hard against a male opponent and felt she learned much of the needs and thoughts of the people of Rabun County. She is the first woman to be elected to the Rabun County School Board.

She is a volunteer for the American Heart Association, speaking when asked on healthy diets for healthy hearts and bodies. She is chairman of the Star Student-Teacher Banquet.

Betsy and her family have hosted exchange students from Argentina, Brazil, Uruguay, and Spain. This really was a window to understanding the value of an education and the importance in having a continued interest in the education of our children.

**Jane Hemmer** is a native Hall Countian, about as native as you can be. She and her husband John and their two sons live on land first settled by her forebears in 1805. She loves Hall County and, although she had no particular interest in politics, she saw the need for a more progressive representation for the undeveloped parts of the county. Two years ago, she ran at-large for one of the five seats on the Hall County Board of Commissioners and won. She is interested in good planning and zoning for the growth that is rapidly coming to Hall County. She is passionately interested in the environment, even calling herself an environmentalist when that isn't always popular. She

is working with industry to "take care of the world." She set up a solid waste management board and helped kick off a recycling plan for the county. She sits on the National Association of Counties' steering committee for energy, land use, and environment. She is on the State Natural Resources steering committee and on an advisory board to the State Human Resources committee, being particularly interested in the problem of the aging.

Jane is a past president of the Hall County Auxiliary and encourages all physicians and physicians' wives to become politically involved, whether as an elected official or by getting to know elected officials and offering input. She says she does see from the inside that elected officials on local, state, and national levels do listen. MAG does an excellent job for medicine, but they need our individual support as well. She used to sit back and assume "somebody else will do that," but not anymore. She became involved.

**Sandra Burk**, wife of Billy and mother of six, has been an active auxilian for years. She has served as president of the Floyd-Polk-Chattooga Auxiliary, as secretary of the Auxiliary to the Medical Association of Georgia, and this year, as the Northwest Georgia legislative chairman. She has also served her community as a member of the Northwest Georgia Girl Scout Executive Board, the YMCA Executive Board, the Floyd Medical Center Foundation, the Rome Symphony Guild, the Board of Directors of Literacy Progress for Rome and Floyd County, and the Georgia School Board Association. For 25 years she has been interested and involved in public education and has seen the opportunities it afforded her children as well as others. When QBE was adopted in Georgia, she decided she wanted to be a part of the sweeping changes in education. So in 1984, she was elected to the Rome Board of Ed-



*Sandra Burk*

ucation and is beginning her third year as chairman. She feels very strongly that education is the key that unlocks the door of opportunity no matter what direction one takes.

Sandra says you must have the support of your family for such an endeavor, not only for the time involved, but because decisions you make will not always be popular and you will need that sanctuary. But she would encourage everyone to get involved because many decisions are made by one voice or one vote. She says she has a deep sense of accomplishment and feels she has left a legacy to her children that says, "It is important to become involved — you have a responsibility to make this world a better place for everyone."

**T**his has been only a sampling of auxilians around the state who are elected officials. There are many others. What an exciting group of public servants! What examples these auxilians are, what milestones they have set, what doors they have opened, what an inspiration they are, and what a difference they have made!



# MRI UPDATE



Figure 1

**CLINICAL INFORMATION:** Non-meniscal abnormalities are commonly suspected and evaluated by MRI and unexpected non-meniscal abnormalities are commonly demonstrated in the course of MR evaluation for internal derangements of the knee.

**FINDINGS:** Figure 1 is a sagittal image through the lateral compartment of a 15-year-old patient's knee. The subarticular portion of the lateral femoral condyle is affected by low signal alteration containing three rounded areas of higher signal intensity. The findings here are diagnostic of osteochondritis dessicans (straight arrows). Notice the normal adjacent anterior and posterior horns of

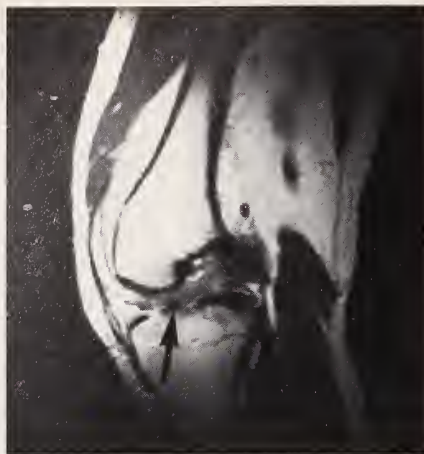


Figure 2

the lateral meniscus (curved arrows).

Figure 2 is a sagittal image through the intercondylar midportion of a 19-year-old patient's knee. The tibial insertion of the anterior cruciate ligament is indicated by the arrow. The remainder of the anterior cruciate ligament is totally disrupted and its expected position is occupied by inhomogeneous material of intermediate signal intensity compatible with hemorrhage. The anterior cruciate has been notoriously difficult to evaluate by MRI, but its reliable evaluation is now possible with careful positioning and rescanning of questionable cases.

Figure 3 is a coronal image of the posterior aspect of the knee



Figure 3

of a 33-year-old patient. The arrow indicates a 1.5 cm. ganglion cyst intimately applied to the lateral aspect of the biceps femoris tendon just proximal to the fibular head. The MR study clearly demonstrates the extra-articular and extraosseous nature of this process.

**COMMENT:** MRI has become clearly established for evaluation of internal derangements of the knee. Meniscal evaluation is known to be highly accurate. The cases shown here are meant to demonstrate the efficacy and accuracy of MR evaluation of extrameniscal structures.



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# Civil War Hospitals Around Chickamauga Battlefield

## *"Marching Through Northwest Georgia"*

Laura M. Crawley

AUXILIANS ALL ACROSS Georgia have long been interested in researching medical heritage with projects including histories of medicine throughout the state, biographies of physicians, histories of hospitals, histories of medical societies and auxiliaries, and accounts of medical discoveries. As early as 1930, Mrs. S. A. Collum, President of the Southern Medical Association Auxiliary, urged the gathering of medical history so that it would be preserved.

Georgia's winning exhibit at the meeting of the Southern Medical Association Auxiliary in San Antonio, Texas, was entered by the Walker-Catoosa-Dade Medical Auxiliary. The Walker-Catoosa-Dade auxiliaries, with a committee of five, compiled a booklet entitled *Civil War Hospitals in Walker-Catoosa-Dade Co., Georgia*, and subsequently developed an exhibit using pictures of the sites covered in the booklet. Since Chickamauga Battlefield, the nation's oldest and largest national military park, is located at Fort Oglethorpe in Walker County, evidences of the Civil War are always present. And since 1988 was the 125th anniversary of the Battle of Chickamauga, which was fought on September 19 and 20, 1863, our thoughts naturally turned to the Civil War period.

The article on the LaFayette Pres-



*The Gordon-Lee Mansion (front entrance). Built in 1847 by James Gordon, located in Chickamauga, GA. Now owned by Dr. & Mrs. Frank Green, it is on the National Historic Register. (Photo by Carolyn D. Crawley)*

byterian Church, founded in 1836, which served as a hospital after the Battle of LaFayette on June 24, 1864, contained two excerpts from personal accounts. The pews were turned together to serve as beds and long tables were moved in for surgery. Dr. G. G. Gordon was men-

tioned as one of the attending physicians.

Dr. Peter Sanford Anderson's home at Rock Springs, Georgia, also served as a hospital. His family refugee south, and he remained behind to care for the wounded. Local tradition has it that General Hood of Texas, who was severely wounded in the thigh, had his leg amputated at this location.

**T**he Gordon-Lee Mansion, now designated as a National Historic Site, and owned by Dr. and Mrs. Frank Green, was built in 1847

Laura Crawley (Mrs. William D.) is Co-Chairman of the Medical Heritage Committee of the A-MAG. She served as editor of the booklets mentioned in the article. She is a geneologist and historian and past president of the Walker-Catoosa-Dade Auxiliary.





*Snodgrass Cabin, located in Chickamauga Battlefield near Ft. Oglethorpe, GA. Used as a hospital site after the Battle of Chickamauga. (Photo by Carolyn D. Crawley)*

by James Gordon and is located at Chickamauga, Georgia. General Rosecrans used the home and grounds as a hospital for the 2nd Division, and seven other hospitals were on the grounds and across the road at Crawfish Springs. The ready availability of water from Crawfish Springs made this a very desirable location. Those hospitals served the 1st Division, 14th Corps; 1st Division, 20th Corps; 1st Division, 21st Corps; 2nd Division, 21st Corps; 3rd Division, 20th Corps; 3rd Division, 21st Corps; 4th Division, 14th Corps. Union casualties after the Battle of Chickamauga numbered 11,500, and the Confederates, 17,000. After the Confederates won the Battle of Chickamauga, the Gordon-Lee Mansion came into their hands (Figure 1).

**T**he Snodgrass Cabin located within Chickamauga Battlefield is another hospital site. It was owned by George Washington Snodgrass, and his wife Mary Elizabeth, at the time of the Battle of Chickamauga. Every year on Memorial Day weekend, the Park Service works with volunteers to stage re-enactments depicting life as it was in 1863. Pictured at the Snod-

grass Cabin is Dr. Anthony Hodges showing an amputating kit (Figures 2 and 3).



*Dr. Anthony Hodges shown at the Snodgrass Cabin, holding an amputating kit. (Photo by Carolyn D. Crawley)*

**T**he *Walker County, Georgia Heritage 1833-1983*, edited by the Walker County Historical Society, lists the John Ross House, built circa 1797, as a hospital site for the treatment of both Federal and Confederate troops (Figure 4). This two-story log house, located in Rossville, Georgia, was the home of Chief John Ross who became Chief of the Cherokee Nation. It is now on the National Historic Register and is open to the public. One interesting account occurred on April 3, 1862, when Dr. Thomas Yandell Park was treating a patient at this house (which was owned by the McFarland family in 1862). A captain Hackett appeared at the door and demanded that Dr. Park leave his patient and lead a group of men to search for James J. Andrews and his raiders who had captured the locomotive, "the General." The raiders were later captured west of Lookout Creek between Chattanooga, Tennessee and Bridgeport, Alabama.





John Ross House, built ca 1797, located in Rossville, GA, was the home of John Ross who became Chief of the Cherokee Nation. (Photo by Carolyn D. Crawley)



The Napier House, built by Thomas Thompson Napier in 1836 is located in Catoosa Co., GA. It was used as a hospital site. (Photo by Carolyn D. Crawley)

The Thomas Thompson Napier House, built in 1836, is still standing and is located on Burning Bush Road in Catoosa County (Figure 5). A descendant, Mrs. Rosa Napier Farrell, and her husband currently live in the home. This lovely home has a 43-foot hall where the soldiers were cared for. Mrs. Farrell, in a personal interview, told of a soldier being hidden by the family in the attic until he was able to travel.

There were several buildings used as hospitals which were located in Catoosa County for which, unfortunately, no photos remain. A marker on the grounds of the Catoosa County Courthouse lists some of these which were: The Buckner Hospital (named for Gen. Simon B. Buckner); the Bragg Hospital (named for Gen. Braxton Bragg); the Foard and Hill Hospitals. There were two large 500-bed hospitals set up at Cherokee Springs and Catoosa Springs. Dr. Samuel H. Stout was Medical Director of all the Confederate Hospitals in Northwest Georgia.

Graphic descriptions of the hospitals in the Catoosa area appear in diaries left by two nurses. Mrs. Fannie Beers, who came to Ringgold in 1862, left a diary called *Memoirs*, published in 1883, in which

she mentions the doctors with whom she worked: Dr. Thornton, Dr. Gamble, Dr. S. M. Bemiss, Dr. Gore, and Dr. Gates. Kate Cumming left a diary which was published in 1866 and is entitled, *A Journal of Hospital Life in the Confederate Army of Tennessee*. Miss Cumming stayed at the Catoosa House while in Ringgold, and her diary mentioned the Buckner and Bragg Hospitals. She said that Dr. McAllister was in charge of the Bragg Hospital, and Mrs. Beers was the matron. In an entry on August 13, 1862, she stated that General Bragg himself was a patient in the hospital.

We felt it was a significant fact there are no hospital sites in Dade County. The reason for this is that the army was marching north from Bridgeport to the area we now know as the Chickamauga and Chattanooga National Military Park. They were in good health when marching through Dade County prior to the Battle of Chickamauga, and after the battle, the mountainous terrain did not make it feasible to go back into Dade County.

The Walker-Catoosa-Dade Auxiliary published the booklets of the Medical Heritage Exhibit and presented them to the libraries in the three counties in honor of Doctors' Day (Figure 6).



Walker-Catoosa-Dade Auxiliaries, Laura Crawley (left) and Dottie Ellis (right) with the Medical Heritage Exhibit. (Photo by Carolyn D. Crawley)



# Shake Up in Physician Reimbursement: Implications for American Health Care Delivery

Alan R. Nelson, M.D.

**T**HEY CAME EXPECTING walkouts, angry haranguing, and deep and unbreechable divisions within medicine. Instead, they saw a serious, searching, critical evaluation of the Harvard Study; they saw bona fide accurate detailing of methodologic flaws in the Hsaio Study; they saw specialists testify in loud clear terms that the TCGs were not listened to carefully enough by the Harvard people; they saw the Board of Trustees do its homework in analyzing the methodology and remaining policy questions surrounding the implementation of Resource-based Relative Value Scale (RBRVS), and they saw the House of Delegates understand the importance of unity of purpose.

The democratic process worked when the AMA House of Delegates in Dallas considered and then took action on the Board report on the RBRVS. The AMA ended up stronger rather than weaker, and many of the observers were frankly disappointed. I've never been happier to see the press guess wrong. They always underestimate us.

What did the Board report say?

1) "That the AMA reaffirm its support for a Medicare indemnity payment schedule in which physicians determine their fees and Medicare establishes its payments using an

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**I believe the total cost would skyrocket in this country with a national health service because demand would increase, efficiency would decrease, and no one would have the guts to ration care.**

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appropriate RVS based on resource costs and an appropriate monetary conversion factor;"

2) That the Harvard RBRVS *when sufficiently expanded, corrected, and refined*, would provide an acceptable basis for an indemnity payment system;

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- 3) That refinement will require
  - Restudy for some specialties
  - Fundamental improvement of measurement of practice costs
  - Development of extrapolation for visits
  - Revision, refinement, and expansion of measurement of pre and post work
  - Better agreement on what services are included in procedures that customarily utilize global fees
  - A better mechanism to feed the input of specialty societies and AMA external evaluations into the Harvard activity as it continues;
- 4) That any payment system must include the right to balance bill;
- 5) That implementation be phased in;
- 6) That geographic variations accommodate differences in practice costs;
- 7) That specialty differentials be avoided — coding systems should permit differences in services and work input to be defined by descriptive codes rather than a specialty differential modifier; and
- 8) That we oppose expenditure targets — a malicious idea that would link a conversion factor to the volume of services.



**I**t should be clear that completion of a new resource based schedule or payments, after all of the above is accomplished, will be just one piece in a complex evolution of change in physician payments.

CPR became moribund in '84 with the Medicare fee freeze. CPR was declared dead in 1986 with imposition of MAAC and inherently reasonable provisions which we have opposed with legislation and lawsuits, but without success. PPRC will recommend a system of physician payment to Congress in April, and HCFA is required by law to do so by end of June. Congress has announced its intention to act — only the nature of the action is unknown.

Meanwhile, in the past few weeks, the Administration has announced a budget that would take \$800 million from physician payments, put more hits on the "overpriced" services via "inherently reasonable" legislation, reduce radiology, anesthesiology, and surgical payments 8%, and freeze all additional fees except primary care.

The Administration favors capitation payments. Pete Stark still wants DRGs for physicians. "Volume control" is the buzzword in government and business discussions alike. How to control the volume of services?

Finally, who will negotiate a conversion factor in a new fee schedule? Who will update it? And what about all of the talk about the Canadian system as a model for the U.S.?

So, any discussion of the RBRVS must be in the context of the relationship of physicians, their patients, and the payers. Talk of "winners" and "losers" based on simulations of phase 1 of the Hsaio Study (which used 1986 data) is misleading. Can anyone seriously think that Medicare will value a family practitioner's office call up by 65% and pay more than Prudential or Blue Shield? And if cataracts

and total hips continue to take 15% yearly hits under "inherently reasonable" provisions, who is to say that payment wouldn't go up under an RBRVS if enough years go by before implementation?

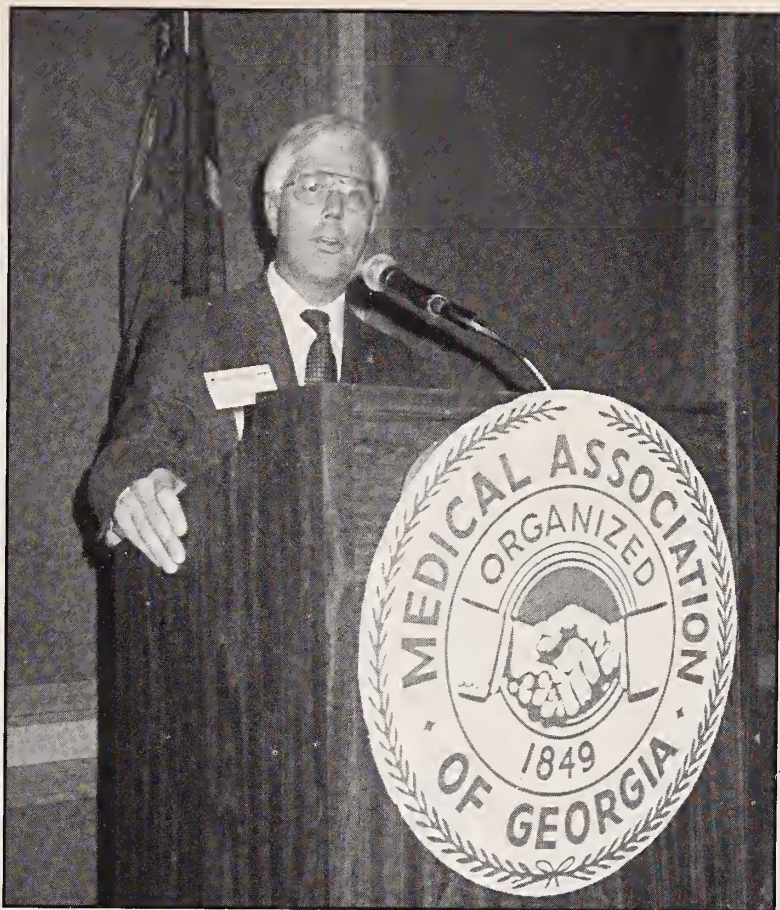
**W**hat we should be talking about is the environment in which these changes are taking place and what we can do to influence change so that we retain the essential values of our profession. What will it take to keep medicine from being converted to a public utility? What will it take to permit us to set our fees, regardless of what schedule of payments is utilized by payers?

We are dealing with a budget driven government policy and an information driven society. The mass media have a strong influence on public attitudes; this often leads to a distrust of institutions, including medicine. Computers permit massing of data (350 million Part B claims per year, for instance), studies of geographic variations, and profiles of facilities and practition-

ers. The learned professions are no longer sacred. The office of the Inspector General assumes that 10% of us are guilty of fraud and abuse and has 300 agents assigned to police physicians.

Mass communications often provides inaccurate or conflicting scientific information because it can't evaluate the credibility of the source. This leads to a schizophrenic attitude of society, enamored of technology and yet fearful of the side effects and negative outcomes.

With this comes a decreasing confidence in our professional integrity and mistrust of our scientific base that results from the information driven nature of our society. Accompanying this has come an erosion of our professional autonomy. There has been an uncoupling of authority from responsibility. Physicians still have the responsibility for the essential decisions in the process of providing care, but their authority to make these decisions with full professional autonomy is challenged by utilization management, PROs, and



*Dr. Alan Nelson, President-elect of the AMA, spoke at MAG's Leadership Conference last February, addressing current issues in medical politics.*



other professions such as nurses, optometrists and pharmacists, and even by our patients.

The second major environmental factor is the cost of medical care as the driving force in evolving government policy and the attitudes of private payers, particularly organized business. Costs have doubled the increases in consumer price index.

There has been a predictable failure of the expectations of preventive health care and competition to control costs. Both increase demand. An increasing aging population, enhanced technology, and increased marketing all have driven up costs. Preventive health care is an important priority for our profession because it enhances the productivity and quality of life for our patients, but preventive health care also results in longer life with a resulting increase in services consumed over the course of that life. Perhaps the single most influential culprit in the cost of medical care today is Sir Alexander Fleming. It was he, you will remember, who discovered penicillin and found a cure for childhood infectious illnesses that formerly tragically shortened the life for many of our people who now live to be 80 or 90 years old and who finally die of a much more expensive illness!

Increased competition results in increased marketing, easy availability of services, demand created by non physician practitioners, with hospital disease-of-the-month clinics and outreach programs, all increasing the volume of services provided and resulting in increased total costs, even though competition may keep the unit cost stable.

George Wills said, at the AMA Leadership Conference, "What do patients want? They want it all!" Patients want everything, and they want to pay for nothing. A 1987 poll asking what is the main problem facing health care was responded to by the public as follows: 67% said cost was the main problem, 16% said quality, and 2% said access. When asked, among other priorities such as education, support for the elderly, and defense,

are we spending too much, not enough, or about right for health care, only 9% answered too much, and 54% answered not enough. This shows the confused nature of the public's priorities regarding health care.

And now, a disturbing trend is appearing in the media coverage combining concern for the 37 million uninsured, quality deficiencies such as inaccurate tests, and poor hospital care, and costs — all with the implication that competition and self-regulation failed and that it is the job of government to fix it, to regulate costs, guarantee access, and set and enforce standards of quality.

**W**hy does this bother me? Remember, we are a media-driven society.

First, pressures will increase, state by state, for mandatory assignment, because AARP has 30 million members and 80% of them vote.

Second, HCFA will continue its collection, study, and release of data on hospital mortality, regional variations on the frequency and cost of procedures, and, ultimately, data on individual practitioners. The director of HCFA has made this clear.

Third, existing laws will be enforced because they were passed with bipartisan support, and the new government will be budget driven as was the last. Thus, the medical necessity provisions will be enforced, although the AMA has achieved major accomplishments in providing greater due process for physicians.

Fraud and abuse, antidumping, and kickback prosecutions by the Inspector General will continue.

The MAAC limits will be enforced, and rollbacks will proceed for 12 "overpriced" procedures, with freezes for non-primary care services and, if the Reagan budget is adopted, additional cuts of 8% for services of radiologists, anesthesiologists, and surgeons.

**A**long with all this, more and more talk is occurring of a national health service as the way to control costs, provide access, and

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**Medicare and non-Medicare patients alike find it tempting to believe that they can have no out-of-pocket costs and no paper work in a national health service — with no downside risk.**

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assure quality. In Canada, 8.4% of the gross national product is spent on health, in Britain, 6.9%, and in Australia, 8.5%. In the United States 10.9% of the GNP was spent on health care in 1987. And yet, the life expectancy in these countries is the same, infant mortality is higher in the United States, and the satisfaction of the public is said to be high in national health services countries. A national health service modeled on the Canadian program has recently been advocated in the *New England Journal of Medicine*. Congressman Pete Stark has also pointed at the Canadian model as one that this country should seriously consider adopting. Medicare and non-Medicare patients alike find it tempting to believe that they can have no out-of-pocket costs and no paper work, in a national health service — with no downside risk. And business will start looking at a national health service as a way to avoid buying insurance for their employees.

**I**n the face of all this, what should we be doing to retain a pluralistic free enterprise system in medicine and retain the essential professional values that are so important to medicine?

We are not helpless, and there is much that we can do. First, we must set our goals. Define those essential elements of our profession, organize, get involved, go to the mat, and win. Physicians are not weak and stupid. We have many resources and a lot of clout if we decide to move.



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## **There has been a predictable failure of the expectations of preventive health care and competition to control costs. Both increase demand.**

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**Goal 1: Professional authority commensurate with our responsibility.** Grant that accountability goes with the territory, and we must commit ourselves to assure quality. If we default on our authority, we can't complain. If I refuse to see one of my patients in a nursing home, I have no complaint if a nurse assumes that role. But patients want an advocate, and they want a physician in charge. This goal is winnable.

**Goal 2: Equity and fairness in reimbursement.** Most physicians work very hard and are worth what they receive. We have no sympathy for the few that have taken a license to practice medicine as a license to steal. We can win the battle over mandatory assignment because it is an equity issue. Society can understand that those who are able to pay a physician's usual fee should do so even though the payment from Medicare is less than that usual fee.

**Goal 3: Full due process in all review.** The vast majority of physicians have appropriate reasons for what they do and are tired of taking the rap for those few that rip off the system. But we must be presumed innocent until proved guilty, and we must rely on education to change behavior, because the vast majority of doctors are motivated and want to practice proper, honorable medicine.

**Goal 4: Freedom to make clinical decisions without being forced into situations of conflict of interest.** I have a great deal of concern about some gatekeeper arrange-

ments that include a risk pool that is substantial enough to create conflict of interest. And the concept of expenditure caps, in which a conversion factor under a relative value schedule would be linked to meeting total expenditure targets, has the potential for creating underutilization.

**Goal 5: Relief from the malpractice crisis.** The AMA's plan for an alternate dispute resolution system has a great potential for the future.

How do we reach these goals? Organized medicine can help but can't do it without grassroots involvement. We must be informed, be willing to write policy makers and, when appropriate, talk to patients.

We must be informed about foreign systems so that we know that the British, Australian, and now the Canadian care is cheaper because of restricted access to rundown facilities, with long waiting lines for elective procedures and often impersonal doctors who don't work very hard because there is no incentive. And we must be willing to tell about it.

I believe the total cost would skyrocket in this country with a national health service because demand would increase, efficiency would decrease, and no one would have the guts to ration care. Certainly, physicians will not ration care on a case by case basis because we are advocates for the patient, and we will provide for our patients what we would want for ourselves under similar circumstances.

To win, we must be personally involved and organized into organizations that are strong, united, triple threat, and willing to take risk with the capability of rapid response. For the American Medical Association, this means a strong organization, well funded, with a strong staff, and strong on communicating the fact that we have the best health care system in the world and that the public will suffer if we convert it to a public utility.

Triple threat means that we confront those who would diminish our

professional autonomy in the halls of Congress, in the offices of the bureaucracy, and, when the welfare of our profession and the rights of our patients are at stake, that we take on our adversaries in the courts.

Finally, being united is especially important with the potential for fragmentation over physician payment. Eli Ginzburg has said, "nothing will contribute more to a further loss of respect and authority by the medical profession than dissension among the specialty and subspecialty groups on the matter of fees. The profession may suffer losses even if it holds ranks, but it runs greater risks if the American people are treated to ringside seats at a bruising battle between those who seek to protect their fees and those who relentlessly seek increases."

We can win in reaching our essential goals and can leave a legacy for those that follow that is rich and satisfying. The "good old days" weren't all that good. We now have the capability of treating a multitude of illnesses and conditions that we were formerly helpless to treat.

**I** believe we are entering what George Lundberg has called the "Golden Age of Medicine." We will unlock the secrets of the cell, find cures for debilitating illnesses, such as Alzheimer's Disease and cancer, and resume our place as community leaders. We will have enough physicians so that we can get prompt referrals for our patients, we will be able to spend some time with our families, again enjoy some leisure time, and, we will make a decent living. The public, I am convinced, does not want doctors with holes in their shoes.

But we must set our goals and work to achieve them: the authority to match responsibility, equity, full due process, freedom from conflict of interest, and relief from the destruction of the current TORT system. If we default on working to achieve these goals, the scientific miracles of the future will not be as abundant for our people because medicine will no longer attract the best and the brightest, as it has in the past and must in the future.

## *Educating People with Congenital Heart Disease*

*Cynthia Murphy, M.D.*

### **Introduction**

**I**N THE PAST 2 decades, major advances in research and technology have allowed children with congenital heart disease (CHD) to survive to adolescence and adulthood. Achieving well-adjusted adulthood is a difficult enough goal for healthy people, and having CHD requires additional adaptations. Parents and siblings must also adapt to live their own lives normally and to help the affected family member live normally. This paper will discuss the perceptions and adaptations people with CHD and their families have. It will also discuss how the physician should educate everyone involved to aid the pursuance of normal, productive, and happy lives.

### **The Experience of Parents of Children with CHD**

Parents experience a wide spectrum of emotions when their child is diagnosed with CHD. Of course, the intensity of emotion and speed with which to adjust varies: a 2-week-old baby who has a hypercyanotic spell, is diagnosed with tetralogy of Fallot, and must have an immediate Blalock-Taussig shunt, is a different scenario from a healthy, active 2-year-old who has an atrial septal defect that can be closed in a few years. The common denominator is the same, however, in that their child has a

defect that disrupts normal daily living. They must face possible loss of the child, hospitalizations, surgery, financial difficulties, and strain among family members. Initial reactions include fear, anxiety, anger, disbelief, and grief over possible death or desired normalcy of their child. They may feel guilty about somehow causing or transmitting the defect or by not recognizing it sooner. These feelings must be vocalized and discussed so that the reality of the defect is accepted and steps may be taken to adjust and to begin appropriate management of the child so s/he may develop as normally as possible.

As will be discussed more later, good adjustment of the parents is essential for normal adjustment and development of the child. Poor adjustment on the part of a child growing up with CHD is related more to a parent's anxiety and overprotection than to the degree of incapacity. A child who is raised by anxious and overprotective parents may accept their pampering and become passive and dependent, or s/he may reject their view and deny

**‘Poor adjustment on the part of a child growing up with CHD is related more to a parent’s anxiety and overprotection than to the degree of incapacity.’**

reasonable medical management and advice. A rarer scenario is one where parents reject or neglect the child and may be detached, uncooperative, and noncompliant.

Successful adaptation is seen in parents who place realistic restrictions on physical activity, if necessary, and encourage self-care, school, relationships, and appropriate recreation.

**T**he first step in a parent's adjustment is being informed and educated about the disease. They should know the anatomy, symptoms, diagnostic procedures, medicines, surgeries, hospitalizations, risks, and prognosis. They need to know that it is OK to discipline their child and what, if any, physical activities should be limited. In fact, parents should be aware that children, before adolescence, generally limit themselves appropriately and rarely overexert themselves. Finally, parents should be informed about

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This article was prepared at the request of the Georgia Affiliate of the American Heart Association. Those wishing to contribute papers to this department should send them to Wesley Covitz, M.D., Heart Dept. Editor, Section of Pediatric Cardiology, MCG, Augusta, GA 30912. Send reprint requests for this article to Dr. Covitz.



frequency of office visits and subacute bacterial endocarditis prophylaxis.

Many times parents will further their education by additional reading which often serves to further lessen anxiety by making the disease more familiar. Parents who continue having difficulty adjusting should be encouraged to partake in group discussions with other parents of children with CHD or seek therapy.

#### Siblings of CHD Children

An often overlooked family member who is profoundly affected by a child with CHD is the sibling(s). Tritt and Esses objectively and subjectively studied siblings of chronically ill children. They found no significant differences in self-concept between affected and non-affected siblings. Siblings of ill children were, however, found to have more behavior problems as perceived by their parents. When interviewed, some common feelings expressed were resentment, abandonment, guilt, and exclusion. Many times the siblings had little understanding of the illness, either due to lack of interest by the child or an unspoken family rule about not asking questions. On the positive side, however, some of the older siblings felt they had more patience, understanding, and sensitivity as a result of living with a chronically ill child. It is

very important, therefore, to include the siblings in education about their brother's or sister's disease and to encourage parents to have open and honest discussions as the children reach different stages of readiness to hear about the disease.

#### Growing Up with CHD

As these children with CHD age, a goal of well-adjusted development is independence. The pathway to independence is becoming responsible for oneself, accepting limitations, and functioning effectively in home and school. They should acquire more understanding about their illness and assist in medical management.

Many studies do show effective psychosocial adjustment among older children and adolescents. Kellerman, et al. found there were no significant differences between healthy and ill adolescents on the measure of anxiety or self-esteem. In fact, cardiac patients reported less impact of illness on popularity and peer activities than did healthy adolescents. They were also reported to have a reduced sense of control over the future of their health which was interpreted as being the result of appropriate self-perception.

Again, as stated earlier, good psychosocial adaptation comes primarily from a family's acceptance of the child's disease

and their encouragement to live as normally as possible. Children and adolescents with prolonged poor adjustment come from families that have poorly adapted. The parents who are fearful and discourage outside interests and activity may have children who are overly dependent, passive, and fearful of their future. Or they may rebel against the over-protectiveness and engage in risk-taking activities.

**“Not only is it important to teach about the disease, therapeutics, prognosis, SBE prophylaxis, and if necessary, physical restriction, it is also important to offer guidance about vocational rehabilitation and having a family.”**

So, in educating families, a physician should go over, again and again, information about the disease, therapeutics, prognosis, and restrictions, if any, on activity. The physician should encourage school, intellectual pursuits, and alternate physical activities. And, with every visit,

the importance of SBE prophylaxis should be stressed. But now, the burden of decision making and caretaking should be handled more and more by the patient. The high school student will want to know about playing sports, what recreations s/he can partake in, and what kind of job s/he can have. They may also be starting to think of marriage and having children. The next sections of this paper will discuss how to educate about recreation, vocation, genetics, pregnancy, and contraception.

#### **Medical Knowledge of Adolescents with Heart Disease**

A study by Ferencz, et al. showed that the education process of adolescents may need some improvement. They found in their study that most of the adolescents (14-21 years old) were unable to describe their heart condition and that fewer than half could correctly describe the surgery they had. The risk factors of adult heart disease were known better than the risks of their own heart disease. Finally, they thought their physical limitations were stricter than they were in actuality, and that their cardiac status was better than the medical records indicated.

This study indicates that a little extra time may need to be taken by physicians to ensure that their patients do have appropriate knowledge about their disease and what they can and cannot do.

#### **Recreation and Sports**

According to Freed's recreational and sports recommendations for the child with heart disease, the child with trivial heart disease (the x-ray and/or ECG are usually normal) should not have any restrictions on recreational or competitive activities. In the child with mild

heart disease (the x-ray and/or ECG will usually be abnormal), recreational activities and nonstrenuous or moderately strenuous competitive activities should not be restricted. Strenuous competition may be acceptable if yearly exercise testing shows no cardiac compromise. The child with moderate heart disease may partake in moderately strenuous and nonstrenuous recreational activities, and strenuous recreational and nonstrenuous and moderately strenuous competitive activity with normal yearly stress tests. Strenuous competitive activity should be prohibited. The child with severe heart disease should be allowed nonstrenuous recreational activity and moderately strenuous recreational activity with normal yearly stress tests. Strenuous recreational activity and moderately strenuous and strenuous competitive activity should be prohibited. Those with active myocarditis and congestive heart failure with ischemia should remain sedentary.

Since recreational and sports activities can be very good ways to achieve socialization, accomplishment, and personal satisfaction, it is important to let a family and child know exactly what s/he can and cannot do. As shown in the study by Ferencz, adolescents may be placing more restrictions than necessary upon themselves and are therefore needlessly limiting avenues of expression and socialization. However, it is just as important not to allow an overzealous father eager for a football player (or a teenager eager to be a football player) to encourage inappropriate activity.

#### **Vocation**

While in high school, most

adolescents are planning future careers. The physician should offer guidance in this area, since there may be additional obstacles healthy teenagers do not have to consider. First, the teenager should be aware of physical limitations. People with normal cardiac function should have no limitations. Those people with mild to moderate disease should be discouraged from labor that requires prolonged lifting of heavy objects (i.e., dock labor). And those people with severe heart disease should be encouraged to pursue more sedentary occupations.

Another obstacle people with CHD face is job discrimination. If physical disabilities are made known, i.e., on the application of a pre-employment physical, most people would not be hired. They would also be denied associated insurance plans. Fortunately, education of employers and insurance companies are improving the chances of being hired and insured, although a lot of work still needs to be done in this area. Since this is a major obstacle to overcome, adolescents with CHD should be directed to vocational rehabilitation programs. Job counseling can help these people find their physical and intellectual level at which to effectively perform in their careers.

#### **Genetic Counseling**

A potential parent with CHD will probably be concerned about the risks of having a child with CHD. Current genetic counseling data continue to grow. To date, Nora and Nora contend that there is a wide range of risk figures influenced by high-risk families, and one should acknowledge the inadequacy of the data base and only provide general guidelines.



**TABLE I — Suggested Offspring Recurrence Risk for Congenital Heart Defects Given 1 Affected Parent (percent)**

Defect	Mother Affected	Father Affected
Aortic stenosis	13-18	3
Atrial septal defect	4-4.5	1.5
Atrioventricular canal	14	1
Coarctation of aorta	4	2
Patent ductus arteriosus	3.5-4	2.5
Pulmonary stenosis	4-6.5	2
Tetralogy of Fallot	2.5	1.5
Ventricular septal defect	6-10	2

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They have studied eight congenital heart defects and have found that maternal transmission of CHD is greater than paternal transmission. Nora and Nora postulate this difference as being secondary to maternal vulnerability to teratogens and cytoplasmic inheritance. Mode of transmission is important in counselling: if autosomal dominance is suspected, one would counsel a 50% recurrence risk; however, if cytoplasmic inheritance is suspected, all offspring are at risk. Table 1 lists the suggested recurrence risk if either the mother or father are affected. Table 2 lists recurrence risks in additional offspring if the parents are unaffected but if one or two siblings are affected.

#### Pregnancy and Contraception

Pregnancy imposes changes in the cardiovascular system that may aggravate a defect in that system. Whittemore, et al. did a study that showed good outcome

**TABLE II — Recurrence Risks in Sibs for Any Congenital Heart Defect: Combined Data Published During Two Decades from European and North American Populations**

Defect	1966-1975 risk %	1976-1985 risk %	Suggested risk %	
			If 1 sib	If 2 sibs
Ventricular septal defect	2.9	4.3	3	10
Patent ductus	2.8	3.2	3	10
Atrial septal defect	2.6	2.9	2.5	8
Tetralogy of Fallot	2.5	2.8	2.5	8
Pulmonary stenosis	2.1	2.0	2	6
Coarctation of aorta	1.9	1.8	2	6
Aortic stenosis	2.1	2.0	2	6
Transposition	1.4	—	1.5	5
Endocardial cushion	2.9	—	3	10
Fibroelastosis	3.8	—	4	12
Hypoplastic left heart	2.2	—	2	6
Tricuspid atresia	1.0	—	1	3
Ebstein anomaly	1.0	—	1	3
Truncus	1.2	—	1	3
Pulmonary atresia	1.3	—	1	3

— means insufficient data.

Reprinted with permission from *American Journal of Medical Genetics* 29:137-142 (1988).

for both mother and infant in those with good and excellent cardiac function. Women who had fair to poor cardiac function were managed satisfactorily therapeutically, although there were several therapeutic abortions for pulmonary hypertension and increase of severity of heart failure. Onset of labor was spontaneous for most of the women, and C-section was performed mainly for obstetric reasons. Women with cyanosis did have a higher occurrence of fetal death or infants who were small for gestational age.

The prospective parents should be aware of increased risks for the mother and/or infant preferably before becoming pregnant, so that an informed decision to become pregnant may be made. If pregnancy occurs unplanned or if her physical condition worsens, the woman must make the decision of taking the risks for herself and her baby, and the question of terminating

the pregnancy should be discussed.

If a woman decides not to get pregnant at that time, or any time, appropriate contraception needs to be discussed. Women who are acyanotic and not in congestive heart failure may use any form of contraception they wish to, except the IUD which may increase the chance of bacterial endocarditis. The oral contraceptive pill is contraindicated in cyanotic women or those with CHF due to increased risk of thromboembolism. They also should not use the IUD. The diaphragm and condom may be safely used if pregnancy may be considered in the future. If the decision to not have children is made, a tubal ligation, or a vasectomy in the partner, may be considered.

#### Conclusion

The goal of all physicians, beyond providing maximum

health care, should be to help their patients be as psychosocially well adjusted as possible.

Education is an essential part of therapy in the care of a child with CHD — first for the parents so they may adapt and accept their child and help him grow as normally as possible. And then for the child, adolescent, and young adult, so s/he may lead normal productive lives. Not only is it important to teach about the disease, therapeutics, prognosis, SBE prophylaxis, and if necessary, physical restrictions, it is also important to offer guidance about vocational rehabilitation and having a family. A physician should also especially promote healthy living by educating about the hazards of smoking, obesity, and drug use and by encouraging healthy eating and exercise. One area of education that is not referred to much in the literature, but is a concern of cardiac patients in the Kellerman study, is sexuality. Therefore, sexual counseling may also be beneficial.

It is heartening that many studies show such good psychosocial adjustment among adolescents and young adults. Good education will ensure that this trend continues.

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*I think people should go into public office for a term or two, and then get back into their businesses and live under the laws that they passed.*

MIKE CURB


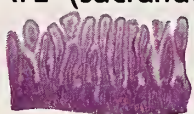

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SAMUEL JOHNSON





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### CONTRAINDICATIONS

There are no known contraindications to the use of sucralfate.

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Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

**Drug Interactions:** Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

**Pregnancy:** Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

### OVERDOSAGE

There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

### DOSAGE AND ADMINISTRATION

The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

### HOW SUPPLIED

CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

### Reference:

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

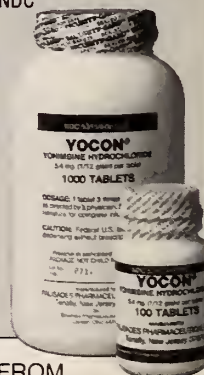
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

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## Physician Liability Under the "Borrowed Servant" Rule

Robert N. Berg

*"Neither a borrower nor a lender be."*  
BENJAMIN FRANKLIN

**Physician liability in connection with the rendering of medical or surgical services may arise in a number of ways. 9**

**A**LTHOUGH Benjamin Franklin's sound advice was directed at the borrowing and lending of money, it is equally applicable to the lending and borrowing of other commodities and goods. Indeed, as highlighted in this month's Legal Page, dealing with the "borrowed servant" rule, the physician who is deemed to have borrowed a hospital's health care personnel may be held liable for their negligent or wrongful acts, despite the fact that the personnel were employees of the hospital.

### The "Borrowed Servant" Rule

Under what is known as the "respondeat superior" doctrine, an employer may be held liable for the negligent or wrongful acts of its employees. As a corollary to this doctrine, the "borrowed servant" rule, as applied in the health care field, provides that "(w)hen a hospital yields control of its employees to a surgeon in the operating room and the

surgeon exercises immediate personal supervision over these employees, then he becomes their master and their negligence during the course of the master/servant relationship will be imputed to him."<sup>1</sup>

In order for a physician to be held liable — and, in turn, for the hospital to avoid liability — under the "borrowed servant" rule, several requirements must be met. First, the hospital must show that it has yielded control of its employees who are assisting in a surgical procedure. Secondly, the hospital must show that the employees whose negligence is sought to be imputed to the physician are under the "immediate supervision" of the surgeon.<sup>2</sup> Finally, the "borrowed servant" rule will be found to apply only to tasks involving professional skill and judgment. The rule has no application, in Georgia, to the negligence of a hospital employee in the performance of clerical or administrative tasks not requiring the exercise of medical judgment, even though those tasks may be related to treatment of the patient and may be performed in the presence of the physician.<sup>3</sup>

This article was prepared at the request of the *Journal*. Mr. Berg is a principal in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., Atlanta, GA 30326. Send reprint requests to Mr. Berg.

**W**hile the "borrowed servant" rule is fairly easy to understand, application of that rule may be far more difficult. For example, in a recent Georgia case, *Ross v. Chatham Hospital Authority*,<sup>4</sup> the Georgia Supreme Court was asked to apply the "borrowed servant" rule in the context of a medical malpractice suit involving a surgical procedure in the hospital operating room. The plaintiff, Mr. Ross, sued the hospital and a surgeon for malpractice, resulting from an instrument being left in the patient's abdomen during surgery. The applicable standard of care in the locality at the time of the surgery did not require a surgical instrument count. As a result, the trial court refused to find the hospital liable for malpractice because its employees failed to conduct an instrument count. Thus, it was left to the court to determine whether the surgeon could be held liable for the acts of the hospital employees, under the "borrowed servant" rule.

The trial court found that, while the hospital had yielded control of its employees to the physician, the physician had not assumed direct personal supervision of those employees. Therefore, the trial court found that the physician could not be held responsible for the negligent acts of the hospital employees.

On appeal, the Georgia Court of Appeals reversed the trial court's decision. According to the Court of Appeals, there was adequate evidence that the physician had provided immediate supervision to the employees. According to his deposition, the physician had stated that he was in charge of the operating room; moreover, the hospital had contended that the physician was present in the

operating room at all times during the surgery. Moreover, the Court of Appeals questioned whether the "borrowed servant" rule required, as an element, that the physician provide immediate supervision to the hospital personnel, as opposed to merely being present during the surgical procedure.

The Georgia Supreme Court, on further appeal, reversed the decision of the Court of Appeals. Interestingly, however, the Court did not base its decision on the question of immediate supervision. Rather, the Supreme Court looked to the issue of whether the counting of sponges and instruments before and after surgery is an act requiring medical skill and judgment or simply an administrative act requiring the exercise of no medical judgment. Ultimately, the Court held that the "borrowed servant" rule had no application, finding that "the counting of sponges, instruments and other items which could be left in the patient during an operation is generally considered an administrative act rather than an act requiring the exercise of professional skill or judgment."<sup>5</sup> Thus, the surgeon could not be held liable for the failure of the hospital personnel to conduct appropriate instrument counts.

**A**s a side note, the Court's decision did not result in the dismissal of the physician from the case. Rather, the Court also held that, while the injury to the patient could have resulted from the administrative acts of hospital personnel, it also could have resulted directly from the failure of the physician to exercise the proper degree of care and skill in the surgery. Specifically, the Court concluded

that "a surgeon's responsibility to assure himself and the patient that no foreign object remains within the body of the patient is an act of medical judgment and skill. A surgeon's failure to properly perform this act can impose liability upon him without respect to the acts or nonfeasance of other personnel in the operating room."<sup>6</sup> As a result, the Court remanded the case to the trial court, for a trial on this issue (and other unrelated issues).

### Conclusion

Physician liability in connection with the rendering of medical or surgical services may arise in a number of ways. The physician may be held liable, under the doctrine of *respondeat superior*, for the negligent actions of his or her employees. The physician may also be held liable, under the "borrowed servant" rule, for certain types of services rendered by hospital personnel (i.e., those tasks involving professional skill and judgment), if the hospital has yielded control of its personnel to the physician and if the physician is directing and supervising those activities. Finally, as evidenced by the *Ross* case, the physician may be held directly liable for the failure properly to direct and supervise the performance of the surgical procedure itself, such as by failing to ensure that a proper post-operation instrument count is taken.

### Notes

1. *Miller v. Atkins*, 142 Ga.App. 618, 236 S.E. 2d 838 (1977).

2. *Id.*, at 619, 362 S.E. 2d at 838. See, also, *McClure v. Clayton County Hospital Authority*, 176 Ga.App. 414, 336 S.E. 2d 268 (1985); *Swindell v. St. Joseph's Hospital, Inc.*, 161 Ga.App. 290, 291 S.E. 2d 1 (1982).

3. See, e.g., *Porter v. Patterson*, 107 Ga.App. 64, 129 S.E. 2d 70 (1962).

4. 258 Ga. 234, 367 S.E. 2d 793 (1988).

5. *Id.*, 367 S.E. 2d at 796.

6. *Id.*, 367 S.E. 2d at 795.



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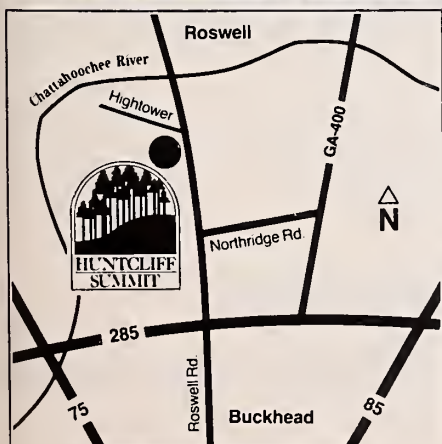
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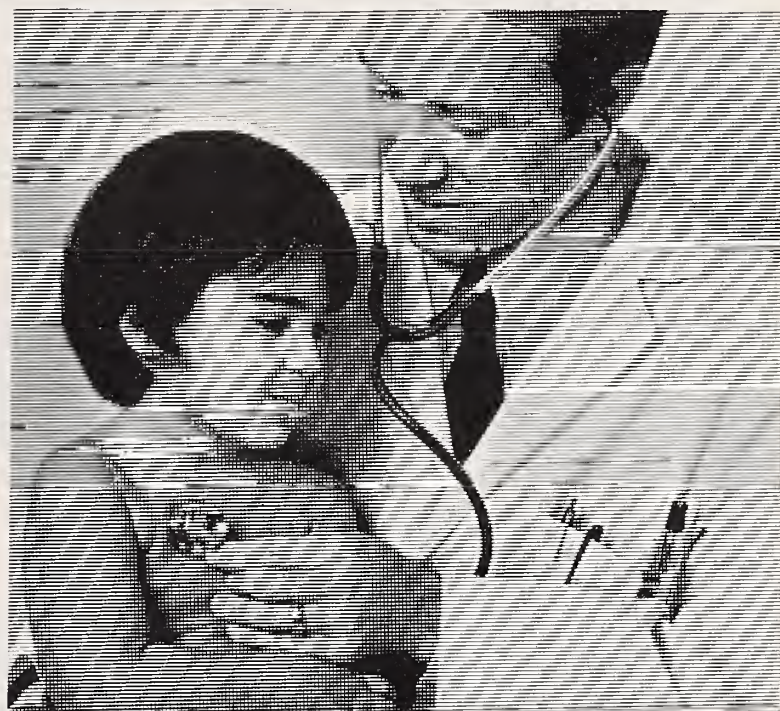
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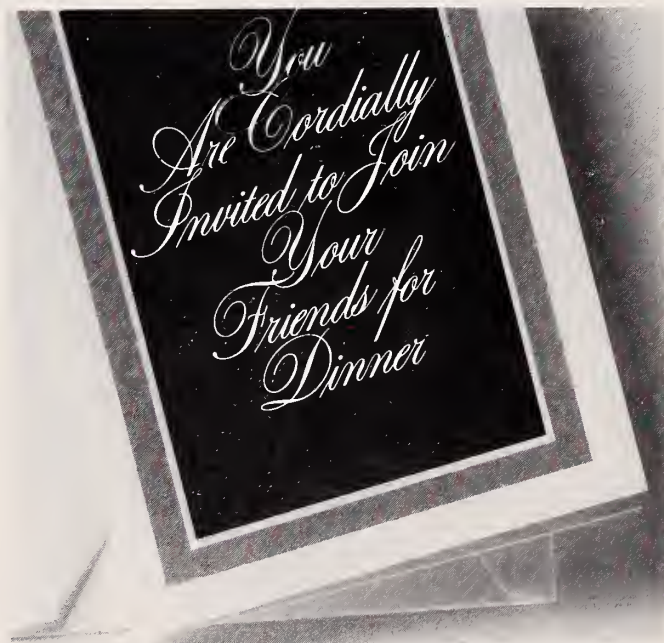
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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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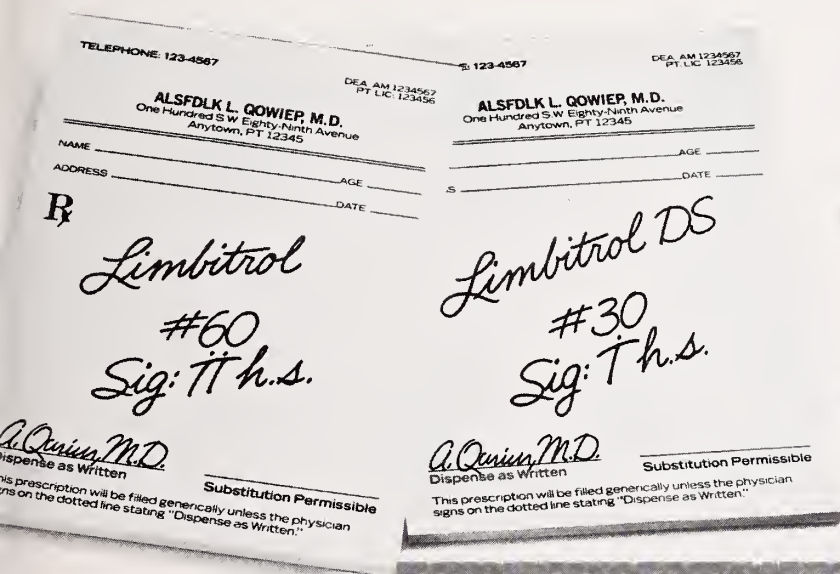
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# In moderate depression and anxiety

- ➔ 74% of patients experienced improved sleep after the first *h.s.* dose<sup>1</sup>
- ➔ First-week improvement in somatic symptoms<sup>1</sup>
- ➔ 50% greater improvement with Limbitrol in the first week than with amitriptyline alone<sup>2</sup>



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**References:** 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

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**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

**Warnings:** Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

**Overdosage:** Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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In the depressed and anxious patient

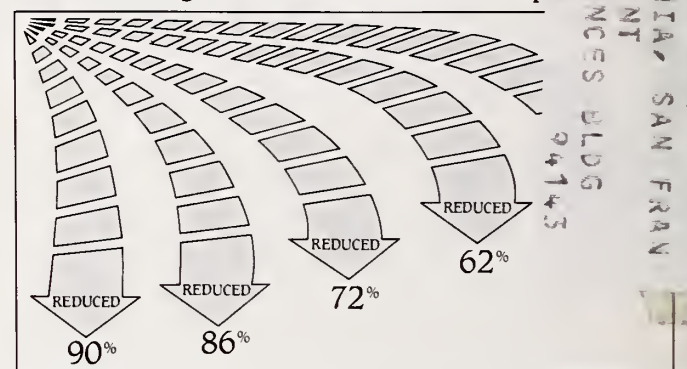
# See Improvement In The First Week<sup>1</sup>

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose<sup>1</sup>
- ➡ First-week reduction in somatic symptoms

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy



VOMITING NAUSEA HEADACHE ANOREXIA CONSTIPATION

\*Patients often presented with more than one somatic symptom.

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JUNE 1989

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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# Ending Up In A Wheelchair Is As Easy As Diving Off A Log




"Or, as it happened in my case, diving off a rubber raft. It started out to be a perfect day. Our senior prom had been the night before and my friends and I were looking forward to a lazy afternoon floating down the river. When the sun really started to beat down, I dove off our raft into the cool water. The next thing I knew, I was lying on the bottom of the river, unable to move."

"I'll be finishing college soon but things are really different now. Because of that one time I didn't check the water level before making a dive, I'll be a quadriplegic for life." -Suzanne Nugent

Swimming and diving accidents that can cause lifetime paralysis are avoidable. So do take chances. Do follow these simple safety rules:

- Swim around in the area to check for hidden objects before you jump or dive.
- Before attempting a dive, jump in feet first to be sure the water is deep enough.
- Never assume an area is safe because other people are diving there, or because you have been swimming there before.
- Never attempt a jump or dive that's beyond your ability.
- Don't swim alone.
- Don't drink and swim.

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## THE COVER

A computer-enhanced image of crushed vertebrae and spinal cord, taken by New York photographer, Howard Sochurek. The *Journal* is indebted to Dr. Fremont Wirth for his efforts in coordinating the articles on head and spinal cord injury prevention in this issue.





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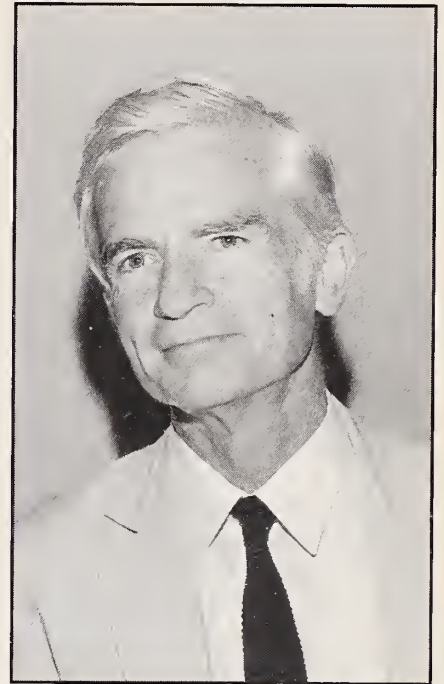
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*Joe L. Nettles, M.D.*

**L**AST NIGHT, I retired early after a busy night on call the previous evening. The telephone awakened me, not with the usual hospital emergency room problem, but with an exuberant young voice.

"Dr. Nettles, this is Kevin, in Athens. I apologize for calling so late, but I just had to let you know that I've been accepted to medical school!"

Kevin had worked with me during summer vacations and whether assisting in the cast room or observing in surgery his enthusiasm and determination was boundless. The more he witnessed the practice of medicine, the more he was determined to be a part of the profession.

I could have pointed out to Kevin the problems doctors now face, such as the professional liability crisis, the justice department threat, the Medicare and Medicaid bureaucratic mess. Then I remembered the day when I told my friends that I was going to medical school. They said, "Joe, you don't want to do that; socialized medicine is right around the corner!"

The threats today are not so much different than the threats back then.

I congratulated Kevin and told him that he will make a fine doctor. I also told him that despite the threats on the horizon, the practice of medicine is the greatest profession in the world.

Let's keep it that way!

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Practice — Bibb — (Resident)  
777 Hemlock St., Macon 31201

Wilson, Frank A., IV, Internal  
Medicine — Sumter — (Active)  
1102 East Lamar, Americus  
31709

Withers, John S., Emergency  
Medicine — MAA — (Resident)  
P.O. Box 15001, Atlanta 30333

## PERSONALS

### *Bibb CMS*

**Rodney M. Browne, M.D.**, of  
Macon, was recently re-elected as  
the 1989 Chairman of the Board  
for the HCA Coliseum Medical  
Centers Boards of Trustees.

### *Georgia Medical Society*

**W. Upton Clary, M.D.**, was  
honored by the Southern  
Neurosurgical Society at its recent  
meeting at Point Clear, Alabama.  
Dr. Clary was awarded the  
Distinguished Practitioner Award  
of the Society. This is the eighth  
such award given during the 41  
years the Southern Neurosurgical  
Society has existed. The award is  
given in recognition of  
outstanding service to patients,  
community, and neurosurgery.  
The award was presented to Dr.  
Clary by Dr. Fremont P. Wirth,  
President of the Southern

Neurosurgical Society and a  
Savannah neurosurgeon.

### *Cobb CMS*

**Mark W. Diehl, M.D.** of  
Marietta, was inducted as a fellow  
the American Academy of  
Orthopaedic Surgeons during the  
association's 56th annual meeting  
in Las Vegas.

**Dirk Huttenbach, M.D.**, has  
been elected to Fellowship in the  
American Psychiatric Association.  
He is president of the Georgia  
Council on Child and Adolescent  
Psychiatry and on staff at  
Ridgeview Institute in Smyrna. He  
is a psychiatrist in private practice  
in Marietta.

### *Dougherty CMS*

**W. Carl Gordon, M.D.**, a  
general surgeon has been named  
medical director for ABC Home  
Health Services of Albany. Dr.  
Gordon is a staff member at  
Phoebe Putney Memorial Hospital  
and HCA Palmyra Medical  
Centers. He is founder and vice  
chairman of Faith Fund  
Foundation, Inc.

### *Newton-Rockdale CMS*

**Gordon C. Carson III, M.D.**,  
was recently appointed Associate  
Professor of Radiology at the  
University of Texas Medical  
School at Houston and named  
Chief of Radiology at the new  
teaching facility, Lyndon B.  
Johnson General Hospital.

## OTHER NEWS

### **MAG Mutual Develops Speakers Bureau**

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since 1982. Since then, your company has grown significantly in the number of policyholders as well as the number of services we provide to the medical community. Now your company is expanding the number of services it provides by developing a Speakers Bureau.

Beginning April 1, MAG Mutual's Speakers Bureau will provide county medical societies, specialty societies, and hospital staffs with speakers who can provide organizations with insurance-related programs that are interesting and educational.

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If you would like one of our speakers to present a program to your organization, please contact us, and we will provide you with the appropriate speaker with a background on his/her knowledge and expertise (404-842-5600).

## DEATHS

**Ebert Van Buren, M.D.**, of Atlanta, an internist for 49 years, died of a stroke last January at Crawford Long Hospital. He was 89.

Dr. Van Buren practiced in Atlanta from 1931 until his retirement in 1980. He opened the first diabetes clinic at Grady Memorial Hospital in the early 1930s.

Dr. Van Buren was born in Utila, British Honduras. He

graduated from Emory University in 1923 and received a degree from Emory Medical School in 1928. He taught in Emory's anatomy department for 1 year

and underwent postgraduate training at Presbyterian Hospital in Chicago. While practicing in Atlanta, he also taught medical courses at Emory.



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Dr. Holwick outside of hospital where she practices as a civilian traumatologist.



Dr. Holwick in operating room at Letterman Army Medical Center

## JANN L. HOLWICK, M.D.

General and Trauma Surgeon.  
Captain, U.S. Army Reserve.

**EDUCATION** University of Southern California, B.S.;  
University of California School of Medicine.

**RESIDENCY** Harbor General Hospital—UCLA  
Medical Center.

**HOSPITAL AFFILIATIONS** St. Luke Hospital;  
Huntington Memorial Hospital, Pasadena, California;  
Traumatologist, Arcadia Methodist Hospital, Arcadia,  
California.

**OUTSTANDING ACHIEVEMENTS** Borden  
Freshman Prize; Alpha Lambda Delta; Phi Beta Kappa;  
Phi Kappa Phi; Bovard Award; ALD Award; American  
Institute of Chemists Medal Award; Summa Cum Laude,  
University of California; Alpha Omega Alpha.

“When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.”

“As a Reserve physician, I’ve had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I’ve grown as a physician and as a person.”

“I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I’ve been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I’m serving my country.”

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harmonious manner with those other parties to such decision making and who will rightfully be involved in those negotiations.

***“We need to take a good look, and that by an independent observer, at our basic organizational structure. At the way we are “organized.” At how we function.”***

Secondly, we must face squarely and defend rationally the obvious fact that physicians, although altruistic by nature, have within themselves the selfsame desire for the comforts, the security, the peace of mind that a fair monetary return for competent and honest work provides. No need now to apologize for that reasonable human drive. A great need, however, to face fairly the inequity, the self-destructiveness of those amongst us, and they are surely there, who see the practice of medicine primarily as just “a good way to make a living.” No longer, if ever, can we afford that element of the profession.

Thirdly, we must come to grips with the obvious mandate, always present but now beyond any freedom to ignore, that we assume our rightful place in the cooperative venture of devising the health care system of the future. We are rushing at an ever-increasing speed into the months and years ahead where we will sit about a table making decisions in concert with others. We must

learn to deal as never before with those we have traditionally seen as subservient to the physician. Learn to deal with them honestly and fairly as equals. The days of “executive sessions” and “turn the tape off” — the days of thinly veiled motives — must be put behind us. From such openness will flow an environment conducive to the development of a health care system unencumbered by greed and self-aggrandisement. A system we have always professed to be our goal — one whose basic purpose is to give optimal care to the sick wherever they are and with whatever means they possess.

**A**nd finally, we urgently need to take a good, hard, practical, and honest look at ourselves. We have rocked along for a number of years now, sort of patching holes in the walls that surround us, too often with little time or effort spent in asking the hard and searching question as to whether or not we are traveling on the road and in the direction of our greatest potential. We need to take a good look, and that by an independent observer, at our basic organizational structure. At the way we are “organized.” At how we function. We need to ask ourselves if in this time a busy practicing physician, possessed of solid interest and unselfish desire, can “run” — be president of — such an organization. We need to question the functional adequacy of changing such a president every 12 months and by so doing interjecting into the organizational flow a new and often non-harmonizing personality with a new agenda for change. We have

***“We must assume our rightful place in the cooperative venture of devising the health care system of the future.”***

over the past few years because of organizational strife and discord engendered in the eyes of some of the public the feeling that we are incapable of smooth, rational, and efficient management of our affairs. Should that perception be true, then our urgent attention to its correction is mandatory. If untrue, a major public relations effort confronts us whereby our inherent ability to govern ourselves becomes obvious to all. We must, for our future will be nurtured by them, attract to the body of organized medicine, and to the ranks of its leadership, the “best and the brightest” of those young men and women entering the practice of medicine in our state.

**W**e live our lives in medicine today more regulated than one would have dreamt possible only a short time ago. We are, however, yet in possession of a degree of freedom — of self-determinism — that is ours to nurture and preserve. Ours also to wantonly destroy. Let us look with clear vision at our past — assess with unflinching and unselfish honesty those decisions and actions which failed us. Humble ourselves to cooperative ventures with our fellow travelers. Staunchly defend that ground only we possess the expertise to hold as our own.

CRU



## Prevention

Fremont P. Wirth, M.D.

*"Humpty Dumpty sat on a wall,  
Humpty Dumpty had a great fall;  
All the King's horses  
and all the King's men  
couldn't put Humpty  
Dumpty together again."*

ANONYMOUS

**T**HIS RHYME, written years ago by an unknown author, too often describes our treatment results in trauma victims. Despite great progress in the management of trauma including improved triage, more sophisticated surgical procedures, intensive care units, hyperalimentation, and fifth generation antibiotics, we cannot correct many of the ravages of trauma in our society. Damage to the nervous system, with its limited regenerative capability, is especially hard to cure. Is it not time to add another phrase to the rhyme?

"Shouldn't we try to PREVENT the fall!"

Characterized by the National Academy of Science in 1966 as the "neglected disease of modern society," injury is a public health problem of immense proportions.<sup>1</sup> It is the leading cause of death for those under age 44 and is the fourth leading cause for all ages.<sup>2</sup> Auto accidents lead as the most frequent cause of death between

the ages of 1 and 34 years and in addition to the 150,000 Americans who die annually from injury, more than 400,000 are permanently disabled.<sup>3</sup> Trauma alone accounts for 3.6 million hospital admissions each year, with an average hospital stay of 7 days.<sup>3</sup> The annual loss of 4,000,000 potential years of life due to injury is greater than the combined losses from cancer, stroke, and heart disease; it is estimated that the cost of trauma approaches \$110 billion annually.<sup>1,2</sup>

**W**hat is to be done? All aspects of this problem are receiving some attention but as a disease, injury needs greater emphasis in our health care planning. The collection of data is vital to any attack on the problem. Georgia is one of nine states with a nervous system trauma registry. On the national level, the Committee of Trauma of the American College of Surgeons is in the process of organizing a national trauma registry. Research in such areas as shock resuscitation, ischemia-reperfusion injury, and other aspects of injury care is receiving more attention. Improved triage and trauma care delivery systems are also being developed in many areas, with improved trauma outcomes for injury victims.

Several of the articles in this special issue of the *Journal* detail the development of head and

***"The physicians of Georgia should take a leadership role and enthusiastically support the Georgia Head and Spinal Cord Injury Prevention Program."***

Dr. Wirth, a neurosurgeon, is with the Neurological Institute of Savannah. Send reprint requests to him at 4 Jackson Blvd., Savannah, GA 31499-3501.

***“There can be no finer representation of the medical profession to the public than the endorsement of an involvement in disease prevention programs.”***

spinal cord injury prevention programs nationally and locally. The emphasis on the nervous system is not meant to exclude but rather to compliment other programs such as Staying Alive and KISS (Kids in Safety Seats). That prevention programs and preventive legislation can be effective is becoming well established. Florida's comprehensive media directed program to prevent diving injuries decreased these accidents by 40%.<sup>4</sup> Other data indicate that programs such as are outlined in the articles in this issue are effective.<sup>5</sup> The dramatic effects of seatbelt legislation are an example of the effectiveness of prevention programs. Seatbelt use is capable of reducing by 60 to 66% of severity of injury, hospital admissions, and costs of hospital care. Mandatory seatbelt legislation in North Carolina is projected to prevent 1100 severe or fatal injuries annually.<sup>6,7</sup>

**T**here can be no finer representation of the medical profession to the public than the endorsement of and involvement in disease prevention programs. The Georgia Head and Spinal Cord Injury Prevention Project is such an enterprise. It has the potential to accomplish a great deal of good for the general welfare of our fellow citizens.

Physicians may attend a presentation in their own area or visit an established program in a nearby community. They will find their time well spent as they witness the interest and enthusiasm high school students in injury prevention programs develop an understanding of the effects of disability. See the film “In Harm's Way,” an award winning film in its own right, and one cannot help but be moved by its strong message of prevention. The physicians of Georgia should take a leadership role and enthusiastically support the Georgia Head and Spinal Cord Injury Prevention Program.

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1. National Academy of Sciences/National Research Council. Accidental Death and Disability: The Neglected Disease of Modern Society. 1966, Washington, DC.
2. National Safety Council. Accident Facts, 1987 Edition. Chicago, 1987.
3. Haupt BJ, Graves E. Detailed diagnoses and procedures for patients discharged from short stay hospitals: United States, 1979. US DHHS Publication # (PHS)82-12-74-1. Washington DC.
4. Saxton C. How to coordinate a multi-agency SCI prevention program. Federated Spine Association, Second Annual Meeting, San Francisco, 1987.
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6. Orsay EM, Turnbull TL, Dunn EM, et al. Prospective study of the effects of safety belts on morbidity and health care costs in motor vehicle accidents. *JAMA* 1988;260:3598-3603.
7. Chorba TL, Reinfurt D, Bulka BS. Efficacy of mandatory seatbelt use legislation. *JAMA* 1988;260:3593-3597.

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## QUOTES

*Probably no man ever had a friend he did not dislike a little; we are all so constituted by nature no one can possibly entirely approve of us.*  
E. W. HOWE



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

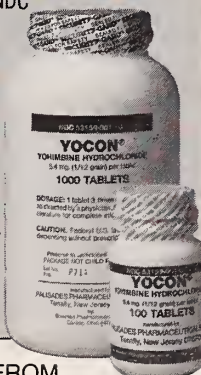
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

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#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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22-25 — *Sea Island: GA*  
**Chapter, American Academy of Pediatricians.** Category 1 credit. Contact William C. Mankin, 4059 Land O' Lakes Dr. Atlanta 30342. PH: 404/237-3922.

23-25 — *Hilton Head Island, SC:*  
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26 — *Atlanta: Breast Cancer:*  
**Conservative Treatment.** Category 1 credit. Contact Donna Cannon, HCA West Paces Ferry Hospital, 3200 Howell Mill Rd., Atlanta 30342. PH: 404/350-5600.

28-July 2 — *Nairobi, Kenya:*  
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29-July 2 — *Kiawah Island, SC:*  
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10-12 — *Kiawah Island, SC:*  
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13-15 — *Kiawah Island, SC:*  
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31-Aug. 4 — *Atlanta: A*  
**Comprehensive Board Review in Internal Medicine.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## AUGUST

10-13 — *Hilton Head, SC:*  
**Georgia Psychiatric Physicians Association.** Category 1 credit. Contact Jim Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

14-18 — *Amelia Island, FL:*  
**Summer Imaging and Interventional Techniques VII.** Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## SEPTEMBER

11-15 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Augusta: Clinical Psychiatry.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-19 — *Atlanta: Third Annual Menopause Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-23 — *Hilton Head, SC:*  
**Frontiers in Nutrition.** Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-23 — *Atlanta: Medical Retina Workshop.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-26 — *Atlanta: Quantitative Thallium Myocardial Tomography.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-28 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXII.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-29 — *Atlanta: Congress of Neurological Surgeons.* Contact CNS, 1840 North Soto St., Room 100B, Los Angeles, CA 90033. PH: 213/224-5435.

25-29 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## OCTOBER

4-6 — *Atlanta: Biliary Lithotripsy and Adjunct Procedures.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: GA Chapter, American Academy of Pediatrics.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30346. PH: 404/237-3922.



# CONTINUING EDUCATION COURSES OFFERED BY EMORY UNIVERSITY DIVISION OF PUBLIC HEALTH

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## COURSE CONTENT

TITLE	DATES	TIME/DAYS	TITLE	DATES	TIME/DAYS
<b>1-WEEK COURSES</b>			<b>1½-2 WEEK COURSES</b>		
1. Public Health Law (3 CEUs, \$200)	June 5-9	9-3 daily	10. Introduction to Management (4.5 CEUs, \$300)	June 22-30	9-3:30 daily
2. Environmental Health Law (1.5 CEUs, \$150)	June 5-9	4:30-6:30 MTWT, 12-6 F only	11. Epidemiologic Applications on the Computer (3 CEUs, \$400)	July 3-14	9-4, daily
3. Biomedical Ethics (3 CEUs, \$200)	June 12-16	9-4 daily	12. Emergency Health Programs in Developing Countries (3 CEUs, \$200)	July 7-21	9-1, MWF (July 14, 3-5)
4. The AIDS Epidemic: Implications for Public Health (1.5 CEUs, \$150)	June 26, 27, June 28	9-12 and 2-5, 9-12	<b>COURSES LONGER THAN 2 WEEKS</b>		
5. Occupational Health (1.5 CEUs, \$150)	July 10-14	4:30-6:30 MTWT 12-6 F only	13. Communication for the Health Care Professional (3.0 CEUs, \$200)	May 23- June 27	6:30-9, Tuesdays
6. Violence as a Public Health Problem (1.5 CEUs, \$150)	July 10-13	1-5 daily	14. Introduction to Epidemiology (4.5 CEUs, \$300)	May 24- June 30	8:30-10:30, MWF
7. Clinic Management (3 CEUs, \$200)	July 24-28	9-3:30	15. Health Education Program Management (1.5 CEUs, \$150)	May 22- July 10	5-7:30 Mondays
8. Occupational Toxicology (1.5 CEUs, \$150)	July 24-28	4:30-6:30 MTWT 12-6, F only	16. Epidemiologic Control of Enteric Disease (2 CEUs, \$200)	May 23- June 29	2:30-5, T and Th
9. Hazardous Waste Management (1.5 CEUs, \$150)	Aug. 7-11	4:30-6:30, MTWT 12-6 F only	17. History of Public Health (1.5 CEUs, \$150)	May 25- Aug. 10	7-9, Thursdays
			18. Computer Skills and Infor- mation Management (1.5 CEUs, \$175)	Session I, June 16, 23, 30 and July 7 Session II, July 6, 13, 20 and 27	9-12, Fridays 6-8:30 p.m., Thursdays
			19. Health Education and the Homeless (1.5 CEUs, \$150)	July 5- Aug. 9	5-8, Wednesdays
			20. Aging and Health Care Issues (1.5 CEUs, \$150)	July 24- Aug. 10	6-8:30, Mondays and Thursdays

**PROGRAM DIRECTOR:** Eugene J. Gangarosa, MD; **PROGRAM FACULTY:** Katie Baer, MS, MPH; Ruth Corcoran, EdD; Eugene J. Gangarosa, MD; Joyce Goldberg, MA; Allan Goldman, MPH; Andrew Robert Greene, JD; Faye Hodgins, RN, PhD, JD; Ronald G. Huggins, PhD, MPH; Fredric D. Kennedy, PhD; Caroleena Lane, PhD; Mike Lane, MD, MPH; Michael Melneck, MPH; Patrick O'Carroll, MD, MPH; Tim Porter O'Grady, RN, EdD; Linda Saltzman, PhD; Aziz Samadi, MD, MPH; Mark Sceigaj, MTS; Jane Seward, MBBS, MPH; Michael Toole, MD; Ronald J. Waldman, MD, MPH

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**L**ISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) January through March, 1989.

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category 1 credit by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Alday, James Malcolm, *Gainesville*  
 Andrews, John S., *Norcross*  
 Appelroth, Danl Jacob, *Atlanta*  
 Auda, Stephen Peter, *Fayetteville*  
 Bates, Jack Miles, *Gainesville*  
 Bates, John G., *Cuthbert*

Becerra, Jose E., *Stone Mountain*  
 Berson, Michael J., *Conyers*  
 Bhole, Raj, *Toccoa*  
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 Bloom, Wm. Frank, *Macon*  
 Brown, Nyda Williams, *Atlanta*  
 Burke, Kenneth Dean, *Bainbridge*  
 Cian, Robt Thos, *Quitman*  
 Cobiella, Angel Manuel, *Mableton*  
 Davis, Lee Swearingen, *Atlanta*  
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 Gonzalez, Pablo Enrique, *Stone Mountain*  
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 Griffin, Howard A., *Waycross*  
 Hannasch, James Donald, *Grayson*  
 Hardman, John Barnett, *Atlanta*  
 Harrold, James Saml, *Evans*  
 Heath, Geo Seaborn, *Waycross*  
 Hill, Julius Napoleon, *Atlanta*  
 Hinkle, James Emrys, *Atlanta*  
 Hinman, Alan Richard, *Decatur*  
 Houk, Vernon Neal, *Atlanta*  
 Huntley, Wm Wayne, *LaGrange*  
 Hurst, James Bonothoe, *Milledgeville*  
 Jacobs, Louis Jerry, *Milledgeville*  
 Jolley, Fleming Lex, *Brunswick*  
 Jurkiewicz, Maurice J, *Decatur*  
 Kelly, Danl Lee, *Augusta*  
 Kirsh, Alan David, *Macon*  
 Kornfield, Marc Joel, *Savannah*  
 Kratina, Fredric Karl, *LaGrange*  
 Lassiter, Nolan Maddox, *Decatur*

Lawson, Herschel Woron, *Atlanta*  
 Mahavi, Kathleen Arnold, *Dalton*  
 Malmer, Bruce Alan, *Atlanta*  
 McCord, Symm Hawes, *Grovetown*  
 McNeill, Nora, *Atlanta*  
 Miller, Frank Richard, *Thomasville*  
 Newton, John Stewart, *Moultrie*  
 Nix, Edward Oliver, *Tucker*  
 Oh, Jung Hee, *Atlanta*  
 Patterson, Homer Scott, *Atlanta*  
 Patwardhan, Ramesh V., *Savannah*  
 Paz, David R., *Newnan*  
 Pendergrast, Wm J., *Atlanta*  
 Pollack, Ross Brian, *Atlanta*  
 Ponce de Leon, Adolfo, *Atlanta*  
 Pound, Edwin Currier, *Atlanta*  
 Powell, Wm Steward, *Griffin*  
 Prisant, Louis Michael, *Augusta*  
 Rendleman, Danl Carl, *Atlanta*  
 Robinson, Donald Ray, *Bainbridge*  
 Rubin, Paul Leslie, *Lawrenceville*  
 Sapp, Philip Bryan, *Dalton*  
 Schieneman, Bruce Owen, *Macon*  
 Schneiderman, Steven M., *Decatur*  
 Shanthaveerappa, Totada R., *Stone Mountain*  
 Slagel, G. Anthony, *Fayetteville*  
 Smith, Geo Leon, *Covington*  
 Smith, Randolph Relihan, *Augusta*  
 Stafford, Chas R., *Gainesville*  
 Stapleton, Tommy Keegan, *Douglas*  
 Tamayo, Elmo Roldan, *Chatsworth*  
 Tillinger, Arnold Jules, *Savannah*  
 Turner, Corbett Harold, *Atlanta*  
 Walker, Maria L., *Decatur*  
 Walker, John Louis, *Atlanta*  
 Weniger, Bruce Gilbert, *Atlanta*  
 Yost, Henry F., *Atlanta*  
 Ziegler, John, *Decatur*



## *The Paleolithic Prescription: A Program of Diet and Exercise and a Design for Living*

by S. Boyd Eaton, M.D., Marjorie Shostak, and Melvin Konner, M.D., Ph.D.

**T**HIS IS AN EXCEPTIONAL book which needs to be read and understood by physicians and others concerned about people's health. It is not easy reading, but the lessons to be learned are important.

All of the authors live and work in Georgia. Boyd Eaton, M.D., is chief of radiology at West Paces Ferry Hospital, a clinical faculty member at Emory, and a member of the State Health Policy Council. Marjorie Shostak is an anthropologist at Emory. She and Melvin Konner, M.D., Ph.D., also

an Emory anthropologist, have written extensively about their research among African hunting and gathering people.

The authors' well supported premise is that aspects of the Paleolithic, or Stone Age, life can be brought into our modern day life and increase the quality and length of our lives. Improvements in nutrition, housing, sanitation, preventive measures, and medical care are recognized as having reduced deaths and disabilities from infection and trauma. Unfortunately, as the authors

demonstrate, many of the diseases which confront us today are due to so little exercise in our lives, the consumption of foods different from those available to pre-industrial populations, and exposure to the damage of alcohol and tobacco.

The authors have successfully challenged the assumption that all has been progress. They have, more importantly, shown ways those of us who wish to take responsibility for our health can benefit from many features of the Paleolithic experience.



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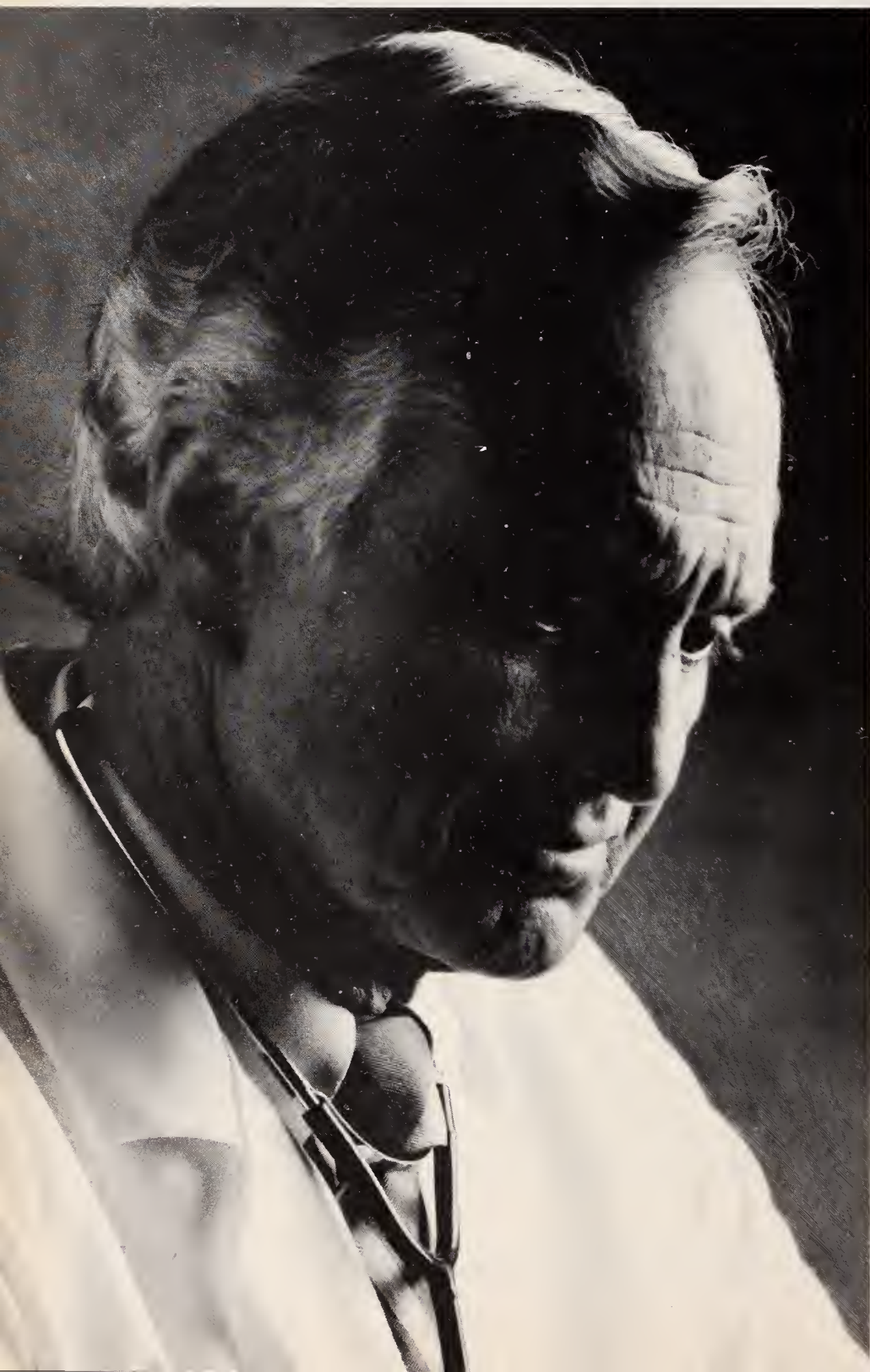
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The circumstances of this claim could occur and have occurred in operating rooms and doctors' offices everywhere. A routine surgical procedure went sour when, for no apparent reason, the patient suffered a cardiac arrest. Prompt and proper attempts at resuscitation failed. Our physician was sued along with other





During discovery, information was released indicating the patient had previously undergone similar surgery under anesthesia *without* incident. Because of ICA's diligence and our willingness to exhaust all legal remedies, the jury was allowed to hear the autopsy report as well as the patient's past medical history. Those defendants who settled quickly never had an opportunity to present that evidence. And ultimately our insured was exonerated.

surgeons in the operating room, the primary care physician, the anesthesiologist and the hospital.

Subsequent to surgery, it was determined the patient had arrested as a result of an allergic reaction to the anesthesia. Unlike other carriers involved, who settled quickly to avoid costly "death incident" litigation, ICA recognized our physician was not at fault. Fortunately for him, ICA is dedicated to the strongest claims defense possible. And because ICA also understands that a doctor's most valuable asset is his reputation, protecting it becomes *our* bottom line.

So ICA and the doctor fought alone — and at ICA's expense. ICA in-house attorneys screened and selected local defense attorneys skilled in malpractice cases and familiar with the judicial climate of the region. Then, they planned strategy, investigated the facts, and monitored the defense.

What does this mean to the doctor? He leaves the courtroom with his reputation, his policy limits and his checkbook intact, all because of his partnership with ICA, where we put reputation, principles and dignity ahead of the quick fix. The reason why? Because ICA is people who *care*. Period.



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### Hospitals Oppose Release of Joint Commission Records

**T**HE GEORGIA HOSPITAL ASSOCIATION and 63 member hospitals have been named defendants in a suit asking for declaratory judgment on whether Joint Commission records used for hospital licensure are public information.

The suit came as a result of a request filed by the *Atlanta Journal and Constitution* and the *Gwinnett Daily News* seeking the reports of all hospitals who submit Joint Commission accreditation reviews in lieu of having the state perform the review. Georgia and 39 other states allow those reviews to take the place of state-conducted reviews.

In their request, the newspapers contended that despite the fact that the Joint Commission reports are given to the Department of Human Resources under an agreement of confidentiality, they should, in fact, be considered public records because they are essentially the same as the state reports, which are public.

In opposing the request, GHA stated that the state had agreed in writing to keep the reports confidential and that because the Joint Commission reviews are in essence peer reviews, the reports are exempt from the open records law. In addition, the hospitals pointed out that Joint Commission reviews are a voluntary effort to seek out every area where improvements can be made, and hospitals depend on

the confidentiality of the reviews as a means of obtaining constructive criticism.

In its opposition to the release of the materials, GHA has emphasized that hospitals are in no way attempting to hide information about the quality of care they provide but are instead insisting that the state keep its promise of confidentiality.

### Only a Weak Correlation Between Mortality Data and Quality

**I**n a HCFA-commissioned study on the value of hospital mortality rates as a measure of quality of care, the Medical College of Wisconsin in Milwaukee has concluded that there is only limited potential to the use of the data.

Though the study found a definite correlation between the two, that correlation was "weak," the study director reported. "There's a lot more to quality of care than mortality. It's unknown how good a measure of quality mortality is."

Even HCFA admits that the mortality data are no "handy dandy guide to hospital quality" but believes it is on the right track in pursuing the data.

### Hospitals Honor Nurses in Annual Program

**I**n an effort to eliminate the shortage of nurses in Georgia, hospitals will recognize 19 nurses nominated in its annual "Nurses

Make a Difference" program May 31. The nurses have been chosen from more than 250 nominations from patients, co-workers, and physicians from across the state, and are being recognized for outstanding work for their patients and hospitals.

At the same time, the hospital association and the Council on Auxiliaries will award nursing school scholarships to eight winners of their annual essay contest. First-prize is a \$4,000 scholarship to the nursing school of the student's choice, and second prize is a \$2,000 scholarship. The other six awards are for \$500, and they are given in each of GHA's geographic districts.

### Prospective Pricing Creeps Steadily Toward Outpatient Surgery

**T**he General Accounting Office (GAO) is now calling for the extension of the Medicare prospective payment system to outpatient surgery.

That move, says the GAO, would save Medicare dollars because it would prohibit hospitals from shifting lost revenues from inpatient surgery to outpatient surgery. And, says the GAO, though it does recognize that hospitals incur greater costs in treating outpatient surgery patients than do ambulatory surgery centers, the government has nevertheless cast a questioning eye on the difference between hospital outpatient charges and those of surgery centers.



## *He Told Us So*

**T**HE EMERGENCY Room physician stated that the Veteran had severe COPD (chronic obstructive pulmonary disease). His medical records indicated that he also suffered from severe anxiety. Being veterans ourselves, it was all crystal clear.

On the evening of admission, his condition had worsened. He told us, "I can't breathe, I can't breathe!" Immediately, our medical minds checked his arterial blood gas, yet there was little change from previous values. No objective evidence of acute respiratory distress. Knowing the routine all too well, oxygen, jet nebulizer, and IV theophylline were begun. Thirty minutes later, he was resting comfortably.

A short social history revealed tobacco addiction, two packs per day of suicidal pleasure, as well as 4 decades of accumulated anxiety. "I've always been like this," he told us, despite the fact that he never smoked before his first ration pack while his anxiety problems began after the war. His battles seemed to continue.

He was divorced and had two children whom he rarely saw. He lived alone, yet infrequently left home, fearful that people were "out to get him." Two months previously, he was hospitalized after similar breathing problems. At that time, we discovered that acute emotional unrest triggered his attacks. With anxiety, he became short of breath, arousing more anxiety, which in turn exacerbated his breathing. A cascade as sure as the

cytochrome system would ensue, with the end result equally sure.

His mother was quite sick and wanted him to care for her when he returned home from the hospital. Moreover, a "relative" stole his last social security check, leaving him unable to pay the monthly rent. Fearing that he could not care for himself much less for his mother, the vicious spiral continued. He seemed to be retreating.

**P**hysically, he knew that his lungs were deteriorating. Fifty, then 40, now 30 yards caused severe shortness of breath. Still, he craved nicotine like an unquenched desert thirst. Deceit came easy. "No, Doc, I quit smoking 6 months ago," he proclaimed while smiling unnaturally. Two hours later, the bathroom air was choked with concentrated smoke. Increasingly trapped in a self-imposed gas chamber, he felt like a desperate P.O.W., watching and waiting. We saw the pattern, and he was begun on anxiolytic therapy with some success. It was a temporary respite.

For three mornings, we attempted to discharge him home, only to find him each time 1 hour later gasping for air. "Slow your breathing down and tell us what's wrong" became automatic phrases and a panacea for his lifelong wounds.

Our tolerance slowly decreased. His unrelenting anxiety made us anxious in our own inadequacy.

Dodging discussions became routine. Other, "sicker" patients commanded more of our attention. Social workers and psychiatry were involved. Daily shots treated the now accustomed anxiety. The ambush began.

**T**hat night, he had severe anxiety once again. The nurses called, stating that he was calling, "I can't breathe, I can't breathe." Upon arriving in his room, he was indeed anxious, but the shots had little effect. Something *was* different this time, only *he* knew it. From pink to blue to ashen gray. Suddenly, *we* knew how he felt. Slumped over the side of his bed, his swollen face and icy cold hands betrayed his resolution for this life. No longer anxious, his solitary war was over.

We jumped into quick action, trying to rescue once again. CPR and rapid intubation, then EKG showing sinus rhythm. We held our breath, listening to our beating hearts. As if to teach us a silent lesson, however, we watched his heart rate deliberately decrease. He died while others walked in and asked "what happened."

**L**ife is worth living when fresh air is ample and the water is crystal clear. He told us so.

*Adam O. Goldstein, M.D.  
Second Year Resident  
Family Medicine  
MCG, Augusta*

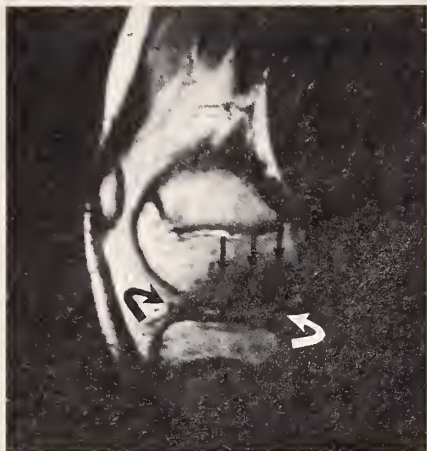


Figure 1

## CLINICAL INFORMATION:

Non-meniscal abnormalities are commonly suspected and evaluated by MRI and unexpected non-meniscal abnormalities are commonly demonstrated in the course of MR evaluation for internal derangements of the knee.

**FINDINGS:** Figure 1 is a sagittal image through the lateral compartment of a 15-year-old patient's knee. The subarticular portion of the lateral femoral condyle is affected by low signal alteration containing three rounded areas of higher signal intensity. The findings here are diagnostic of osteochondritis dessicans (straight arrows). Notice the normal adjacent anterior and posterior horns of



Figure 2

the lateral meniscus (curved arrows).

Figure 2 is a sagittal image through the intercondylar midportion of a 19-year-old patient's knee. The tibial insertion of the anterior cruciate ligament is indicated by the arrow. The remainder of the anterior cruciate ligament is totally disrupted and its expected position is occupied by inhomogeneous material of intermediate signal intensity compatible with hemorrhage. The anterior cruciate has been notoriously difficult to evaluate by MRI, but its reliable evaluation is now possible with careful positioning and rescanning of questionable cases.

Figure 3 is a coronal image of the posterior aspect of the knee



Figure 3

of a 33-year-old patient. The arrow indicates a 1.5 cm. ganglion cyst intimately applied to the lateral aspect of the biceps femoris tendon just proximal to the fibular head. The MR study clearly demonstrates the extra-articular and extraosseous nature of this process.

**COMMENT:** MRI has become clearly established for evaluation of internal derangements of the knee. Meniscal evaluation is known to be highly accurate. The cases shown here are meant to demonstrate the efficacy and accuracy of MR evaluation of extrameniscal structures.



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# The Savannah Head and Spinal Cord Injury Prevention Program

Andrea S. Barch, R.N., Fremont P. Wirth, M.D.

**F**ROM A RATHER primitive effort in 1985 to an entertaining and sophisticated presentation today, the Savannah Head and Spinal Cord Injury Prevention Program (SHSCIPP) has developed over the past 4 years. With only limited financial resources, this has been possible through the generosity and dedication of several neurosurgical intensive care nurses with the support of fellow nurses, physicians, EMTs, occupational and physical therapists, and other hospital personnel. Individuals, businesses, and hospitals in the Savannah community have in many instances lent support of time and resources. Although such efforts on the part of the hospitals may be considered as marketing, they represent a credible standard of such activity. The Savannah experience in developing its Head and Spinal Cord Injury Prevention Program demonstrates that much can be accomplished by a few committed individuals with limited expenditures.

In late winter 1985, Savannah's community hospitals (St. Joseph's Hospital, Memorial Medical Center,

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**From its early beginnings, the Savannah group recognized the need for a strong educational component to the overall Program. Classes covered anatomy, consequences of injury, prevention measures, and lifestyle changes after injury.**

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and Candler General Hospital), under the direction of Fremont P. Wirth, M.D., initiated a spinal cord injury prevention project. The project followed the format of a program designed by E. Fletcher Eyster, M.D., of Pensacola, Florida,

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Ms. Barch is with the Department of Nursing, St. Joseph's Hospital, Savannah; Dr. Wirth is with the Neurological Institute of Savannah, #4 Jackson Blvd., Savannah, GA 31499-3501. Send reprint requests to Dr. Wirth.

"Feet First, First Time" (FFFT). This program was designed to teach youth, from elementary to high school age, about water safety, in particular, safe diving. The message was simple, go into the water feet first, the first time to check the level and condition of the water to ensure safe diving. It had an attractive logo and a record of success over several years in Florida.

With monies donated by the Savannah hospitals and a local neurosurgical group, a T shirt campaign, along with classroom education, began in late spring of 1985. Our initial efforts were primitive. Four nurses conducted the entire program for the first year. They had available no monies, no obstacle course, and limited funds for other equipment. Nonetheless, over 500 students were contacted during the spring and summer. Enthusiasm for the program was high.

**E**ncouraged by the response of students and the community, the hospitals and teaching volunteers decided to continue the pro-





*A high school student experiences the difficulties of using a standard telephone from a wheelchair as part of the wheelchair obstacle course during an SHSCIPP Presentation at Savannah Country Day School.*

gram in 1986. The hospitals donated more funds, and hospital employees were permitted to leave their jobs to teach classes. One hospital donated billboard space, placing signs emphasizing the FFFT logo throughout Chatham County. Another hospital encouraged their Community Relations Department to assist with development and marketing of the Savannah Program which assistance was particularly helpful. One Public Relations Department assisted in the production of a 15-minute slide presentation with a synchronized tape. This greatly improved the quality of the programs presented to the students. In addition, this department coordinated all classes for 1986, enlisting the aid of 25 volunteers. These volunteers were gleaned from all the hospital's nursing, physical/occupational therapy departments and EMTs, and included spinal cord injured volunteers.

Other donations of time and money were received from the community. A local merchant and a radio station combined resources to produce a radio broadcast from Sa-

vannah Beach emphasizing diving safety. A local neurosurgeon purchased the film "Consequences," a movie about the effects of spinal cord injury for use with the in-school programs. And *Feet First, First Time* (FFFT) signs were purchased by the County Leisure Services Department and placed at public boat ramps, beaches, and pools.

The program was expanded in 1987 despite the loss of some financial support. Two hospitals sent nursing personnel to Pensacola, Florida, to learn more about the Florida and national programs. Upon return to Savannah, it was decided to expand the program incorporating both Florida and national guidelines which included head and spinal cord injury prevention. With these changes, the title *Feet First, First Time* was no longer appropriate. The program was renamed the *Savannah Head and Spinal Cord Injury Prevention Program* (SHSCIPP).



*Emergency Medical Technicians demonstrate immobilization techniques for injury victims at SHSCIPP Presentation at Savannah County Day School.*

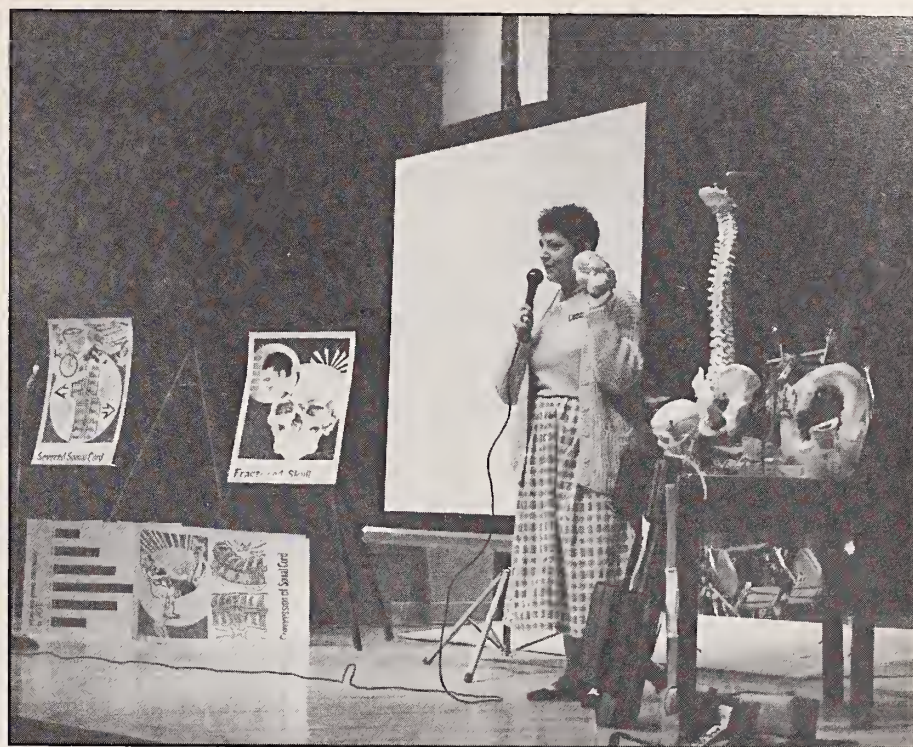


The focus of 1987 was to find funding for a coordinator to develop a Georgia Head and Spinal Cord Injury Prevention Program and to expand the existing educational component of the Savannah program. As the program developed, the Chatham County School Board incorporated it into the curriculum of its 9th grade Health Science Classes (a required class for all Georgia high school graduates). While this recognition was exciting and appreciated, the increased demand for manpower to support the Program was even more apparent. A campaign to attract qualified instructors was launched. The response of nurses, therapists, EMTs, and others was enthusiastic, and these demands for more personnel were met. Over 2,000 students were exposed to this expanded program in 1987.

In April of 1987, at the Annual Meeting of the American Association of Neurological Surgeons in Dallas, Texas, a meeting was held of those interested in the development of National and State programs for Head and Spinal Cord Injury Prevention. Savannah was represented at this meeting and participants were encouraged by the interest of others wanting to form State groups.

To encourage the development of a statewide program, the Savannah group was invited to present their program at the Georgia Neurosurgical Society's Annual Meeting. The interest among those present was again encouraging. Shortly after the meeting, a program was initiated in Augusta with support and advice from the Savannah group.

In 1988, the Savannah Program became even more refined with the inclusion of spinal cord injured volunteers in some presentations. An apparent but difficult to document decrease in the number of spinal cord injuries in the Savannah area has been encouraging but much remains to be done. Although many Chatham County students have been reached by the Program, those in neighboring communities have not. Expansion to neighboring communities requires financial re-



*Andrea Barch, R.N., reviews neuro anatomy and discusses mechanisms of brain and spinal cord injury at SHSCIPP Presentation at Savannah Country Day School.*

sources not yet available for educational materials, transportation, and compensation of personnel needed to put on the program. The funds recently made available to develop a statewide program will provide financial assistance to help overcome some of these barriers and aid in the development of new programs.

Funding became available in June, 1988, through the State Department of Human Resources Division of Rehabilitation Services to promote and develop standardized head and spinal cord injury prevention programs throughout the State. Working with Debbie Tillman, R.N., the new Director of the *Georgia Head and Spinal Cord Injury Prevention Program* (GHSCIPP), the Savannah group will continue to support the State Program by serving as a resource, role model, and training ground for new programs.

From its early beginnings, the Savannah group recognized the need for a strong educational component to the overall Program. Classes covered anatomy, consequences of injury, prevention measures, and life-style changes after injury. Ini-

tially this was done in small classroom settings but this has been changed to general assemblies.

As now presented, these programs last between 45 and 60 minutes, depending on the time allotted by the individual school. A team approach is used in the presentation. After a brief introduction to the purpose of the Program, a film "In Harms Way" is shown. A nurse then briefly covers the topic of brain and spinal cord anatomy and the consequences of injury. Other health professionals such as EMTs and physical/occupational therapists discuss the sequence from injury through rehabilitation. The last and longest component of the program is devoted to discussion by a spinal cord injured volunteer of the changes which occur in one's life after injury. A question and answer period then follows. Student participation is enthusiastic and creates an atmosphere of concern for their own safety and well being.

With the high level of student interest and commitment from hospitals, community and health care



providers, the SHSCIPP continues to set short and long term goals. In 1989, the goals include: development of an obstacle course for use in the high school program, administration of pre and post-testing to evaluate program effectiveness, expansion to surrounding counties, and continued support for the development of a Statewide program. Long-term goals include: the acquisition of funds to expand the existing program and the development of research tools to document the effectiveness of the Program.

As an outcome of past goals, over

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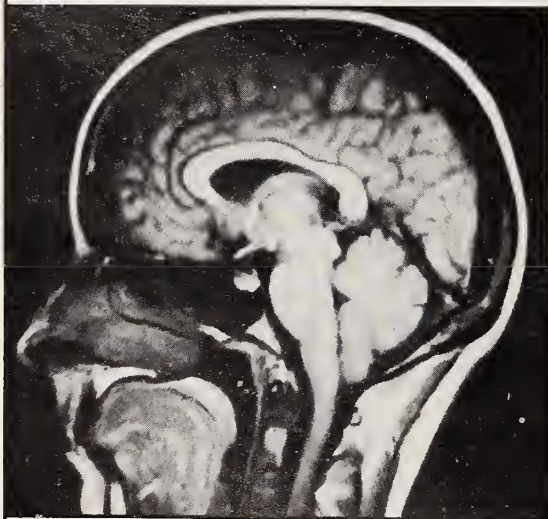
**As an outcome of  
past goals, over 3,000  
students have been  
exposed to the  
Savannah Head and  
Spinal Cord Injury  
Prevention Program.**

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3,000 students have been exposed to the SHSCIPP. These encouraging numbers have contributed to the continued dedication and support of the hospitals, nurses, neurosurgeons, EMTs, physical/occupational therapists, and the community as a whole.

The future of the *Savannah Head and Spinal Cord Prevention Program* is encouraging. Continued support, new challenges, goals, and expectations are readily accepted. Limited finances and a wealth of dedication only seem to encourage this group to push ahead.

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# Participation in Prevention: The Georgia Head and Spinal Cord Injury Prevention Program

Debbie Clough Tillman, R.N., Fremont P. Wirth, M.D.



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Head and Spinal Cord

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INJURY PREVENTION PROGRAM

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**I**NJURY PREVENTION should be the goal of all members of society. Prevention fosters the elimination of disease/illness, trauma, and carelessness through continual education of the society in which we live. Every member of the health care team, physicians, nurses, administrators, and EMTs, to name a few, have a leadership role to play in the prevention of injuries, especially the devastating ones to the nervous system. Public education is fundamental to this process. The lay person frequently does not understand that central nervous system damage is permanent. Reports of the reattachment of a dismembered limb and its functional use may mislead people to believe that

regrowth of nerves will also occur in the brain and spinal cord following injury. This belief may foster risk taking in young people who assume that modern medical technology will be able to restore normal function after injury.

National statistics for head and spinal cord injury in the United States have been reported elsewhere in this issue of the *Journal*. Annually in Georgia, approximately 200 persons will sustain a severe spinal cord injury.<sup>1</sup> This will result

in an estimated 90-day acute hospital stay and 3 months of rehabilitation. These costs may be expected to average \$150,000/injury.<sup>2</sup> The life expectancy of those injured at age 20 will decrease from 75 to 50 years.<sup>1</sup>

In Georgia, approximately 10,000 persons will sustain a head injury this year. Of these, 1,600 will die, and 1,400 will require lifelong care. The estimated lifetime costs for a person who sustains a severe head injury is 1.3 million dollars.<sup>3</sup> Leaving aside humanitarian considerations, the economic impact of these figures is staggering. The people and institutions of Georgia, be they public or private, cannot afford these costs.

Cost, however, accounts for a fraction of the burden those injured experience. Once productive individuals, usually male (although female injuries are on the rise) between the ages of 15-35, find themselves forced into a life not previously imagined. A freedom centered world changes to one involving social workers, nurses, doctors, therapists, and other mem-

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Ms. Tillman is Director, GHSCIPP, c/o St. Joseph's Hospital, 11705 Mercy Blvd., Savannah, GA 31420; Dr. Wirth is with the Neurological Institute of Savannah. Send reprint requests to Ms. Tillman.

bers of the rehabilitation team. The emotional trauma of nervous system injury is difficult to imagine and challenging to correct. Frequently, the individual injured and his or her family require psychological counselling to cope with the physical, sexual, financial, and emotional consequences of the injury.

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**The Georgia HSCIPP is an opportunity to develop a truly effective prevention program for an expensive and frequently incurable disease affecting our youth. The support of the medical profession is essential.**

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It is heartbreaking to tell a parent or a spouse that their loved one will be paralyzed or mentally different for the *rest of their life!* Often, little can be done to eliminate this anguish. Trauma prevention holds more promise than imperfect therapy.

#### **Development**

In 1974 and 1977, two separate head and spinal cord injury prevention programs were developed by Dr. Clark Watts of Missouri and Dr. E. Fletcher Eyster of Florida. In 1986, with the support of the Congress of Neurological Surgeons and The American Association of Neurological Surgeons, these two groups combined their efforts to form the National Head and Spinal Cord Injury Prevention Program. The focus of this program has been and continues to be education for the prevention of injury. Details of the development of this effort are outlined in this issue.

A program along these lines was started in Savannah in 1985. This program, the development of which is detailed elsewhere in this issue, was a cooperative effort of the three local hospitals and members of the health care professions, including physicians, nurses, EMTs, occupational and physical therapists, administrators, and public relations personnel. While this program was effective and expanded its efforts locally, it became apparent that many more programs would be needed throughout the state if a significant percentage of Georgia's young people were to be contacted. Presentation of the Savannah Program to the Georgia Neurosurgical Society in 1987 heightened the interest of neurosurgeons across the state, but seed money to initiate programs in new communities was lacking. With the endorsement of the Georgia Neurosurgical Society, sources for funding through various agencies were sought. The Division of Rehabilitation Services of the State of Georgia, under the direction of Thomas R. Gaines, funded the development of a statewide prevention program in 1988.

In June of 1988, the Georgia Department of Human Resources, Division of Rehabilitation Services, awarded a 2-year \$120,000.00 grant for the development of a Georgia Head and Spinal Cord Injury Prevention Program (GHSCIPP) with Fremont P. Wirth, M.D., as Medical Director and Debbie Tillman, R.N., as the State Director. This is an exciting opportunity, but the work toward an effective state program has only just begun.

The Georgia HSCIPP has been developed to follow the guidelines of the National HSCIPP. Other State programs taking this approach include Missouri, Florida, Arkansas, Oregon, Texas, Illinois, Kansas, and Iowa. The four basic components of the National program are: 1) Basic Education, 2) Reinforcement, 3) General Public Education and 4) Legislation.

The Georgia HSCIPP goals over the next 2 years will focus on the following:

1. Contacting and obtaining commitment for local program development from medical institutions, neurosurgeons, and other physicians throughout the state.
2. Compiling and maintaining a registry of institutions with programs throughout the state.
3. Developing a mechanism of updating coordinators and instructors via a semi-annual newsletter.
4. Conducting training workshops for coordinators.
5. Monitoring the affects of the program on the students by testing (pre and post).
6. Campaigning for additional financial support.
7. Conducting prevention programs throughout the state reaching over 5000 students of high school age initially.
8. Increasing public awareness of all citizens through public education on radio, television, billboards, etc.
9. Increasing awareness of the social and economic consequences of head and spinal cord injury among all health care professionals and eliciting their support and participation in this prevention effort.
10. Serving as a resource for information relating to head and spinal cord injury for government agencies, legislators and other citizen groups in the State of Georgia.
11. Encouraging expanded government support for head and spinal cord injury prevention programs in Georgia.

The Savannah program has incorporated the four basic components of the National Program since 1985 and has been supported by St. Joseph's Hospital throughout its existence. The GHSCIPP is headquartered at St. Joseph's Hospital in Savannah and uses the existing program as a model for other institutions throughout the eight districts in Georgia. The program has been established to collaborate with health professionals and medical



institutions throughout Georgia to begin satellite programs in each of the eight districts. It is planned to develop as many satellite programs as possible under the supervision of the State Director in order to provide a standardized program. Each district coordinator will be formally taught methods of instruction and given guidelines for presentation of the program following the national HSCIPP syllabus. In addition, guidelines for speakers, educational materials, and financial/marketing ideas are discussed. Follow-up correspondence and visits are made after the initial training session to ensure compliance and standardization of the program. Further visits and correspondence will be available upon request.

Neurosurgeons and many institutions throughout Georgia have been notified of the GHSCIPP and the training program. Interest and enthusiasm to begin programs throughout the eight districts is on the rise. At the present time, seven institutions have agreed to act as satellites for their districts. These include Athens, Augusta, Gordon

## **The GHSCIPP is headquartered at St. Joseph's Hospital in Savannah and uses the existing program as a model for other institutions throughout the eight districts in Georgia.**

County, Rome, Savannah, Thomasville, and Valdosta. Although interest is growing, so are hospital costs. It is understandable that not all institutions have the financial freedom to support the GHSCIPP. With this knowledge, the GHSCIPP will assist committed institutions with audiovisual materials, promotional activities, and instruction for the development and expansion of the satellite program. In addition to recruiting new institutions, existing programs have instructed over 700 students in the last 6 months. The development of a pre and a

post-test has facilitated the evaluation of program effectiveness.

**T**he Georgia HSCIPP is an opportunity to develop a truly effective prevention program for an expensive and frequently incurable disease affecting our youth. The support of the medical profession is as essential to its success as the program is deserving of such support. On February 24, 1989, the GHSCIPP held the first free workshop at St. Joseph's Hospital in Savannah. Other workshops are planned. Anyone interested in additional information about the program or workshops should contact Debbie Tillman, R.N., Director of the GHSCIPP at 912-927-5162 or 1-800-543-2482.

Your input is welcome!

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3. Georgia Head Injury Association, P.O. Box 95217, Atlanta, GA 30347.

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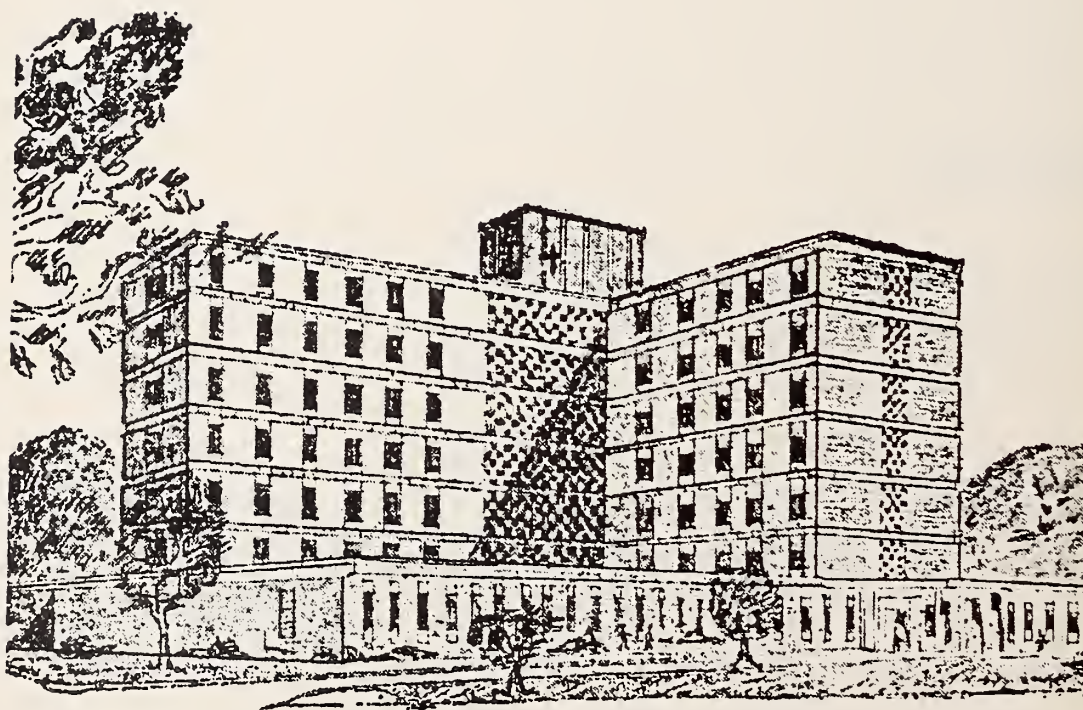
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INJURY PREVENTION PROGRAM

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# The National Head and Spinal Cord Injury Prevention Program

E. Fletcher Eyster, M.D., Clark Watts, M.D.

## Introduction

**T**RAUMATIC INJURY has become a major health care cost in our country, both in terms of the human losses of death and disability and in financial cost.<sup>1</sup> Annually, over 100,000 people suffer head injuries severe enough to cause lifelong physical and mental problems. Two-thirds of these are under age 30.<sup>2</sup> Injuries are the most common cause of death and permanent disability in the age group 1-35, with a significant concentration of these injuries in the 15 to 25 age group.

It is estimated that 40% of the health care dollars are consumed by direct and indirect medical cost of injury, amounting to over 100 billion dollars per year; a major portion of these injuries occur to the head and spinal cord.<sup>2</sup> Permanent disability as a result of these injuries far outweighs, in social impact, injuries to other systems.

Society cannot afford the continued loss of young lives and the extremely high cost of medical treatment of head and spinal cord injuries nor the cost of supporting

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**In 1974 and 1977, two different head and spinal cord injury prevention programs were organized and in 1986, these two groups combined their efforts to form the National Head and Spinal Cord Injury Prevention Program.**

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those who are permanently disabled from head and spinal cord injuries. Efforts to prevent this tragedy are justified on moral and ethical grounds as well as for economic considerations. As neuro-

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surgeons, we are called upon to treat these individuals, and we become frustrated by how little we can do to improve the neurologic deficit. Therefore, it seems logical that we take an active role in trying to prevent these same injuries. The National Head and Spinal Cord Injury Prevention Program is an attempt on the part of the Congress of Neurological Surgeons (CNS) and the American Association of Neurological Surgeons (AANS) to fulfill this role.

## Injury in America

*Injury in America*,<sup>1</sup> a report of the National Academy of Sciences, concluded in 1985 that injuries are the greatest health hazard in America today and labeled it an "epidemic." The report noted that the problem seems to be worsening with time and is complicated by failure of society to seriously grapple with the problem. Of all monies allocated for basic and clinical research in the biomedical arena, only 2% of the funds are allocated to injury research. One can conjecture



Figure 1 — Feet First First Time Logo.

***Injury in America, a report of the National Academy of Sciences, concluded in 1985 that injuries are the greatest health hazard in America today and labeled it an "epidemic."***

that this may be one of the reasons why so few advances have been made in the last 20 years in our ability to successfully treat and reverse the devastations produced by neurologic injuries.

The *Injury in America* report was the subject of a meeting held by the Washington Committee of the AANS and CNS in Dallas in the summer of 1985. It was acknowledged at that meeting that trauma to the head and spinal cord is a significant problem which neurosurgeons are forced to deal with every day, and it was also acknowledged that, while advances in methods of initial treatment have

significantly improved mortality, the ability of neurosurgeons to favorably impact upon long-term disabilities is extremely poor. It was also acknowledged that there is nothing on the scientific horizon suggesting that this state of affairs will be improved upon in this century. Consequently, the Washington Committee of the AANS and the CNS recommended that national neurosurgery undertake a nationwide program of prevention.

The meeting in Dallas in 1985 of the Washington Committee focused primarily upon presentations by two neurosurgeons, the authors of this paper. They presented their experience with educational prevention programs that they had utilized at their institutions for a number of years. After the presentations and discussion by the attendees, the president of the neurosurgical groups unanimously recommended that national neurosurgery accept the challenge of developing and promoting a program of education regarding the natures of head and spinal cord injuries, their impacts upon society, and their prevention. The AANS and CNS accepted the responsibility jointly for this effort. E. Fletcher Eyster, M.D., from Florida, and Clark Watts, M.D., from Missouri, were directed to develop a program incorporating the best aspects of the experience from the Florida and the Missouri programs that could be nationally promoted. This program basically contains four components. The primary component is an education of young people, utilizing the public school system regarding head and spinal cord injuries. Two additional components would merge a re-enforcement of this basic educational effort for young people into an educational effort for the general public. The final component would contain a strategy for attempting to alter public policy toward trauma



Figure 2 — Boy Scout placing warning sign at a beach.



in general, and, specifically, trauma to the nervous system, through political and legislative means.

**Historical Perspective**

*The Florida Program*

In 1974, the Florida legislature passed a law mandating the creation of a central registry for spinal cord injuries. In 1976, the legislature followed up with the Ombudsman Nursing Bill mandating the creation of a statewide plan for the care of spinal cord injuries. This plan created a Spinal Cord Injury Advisory Council to Health and Rehabilitative Services. This Advisory Council had the duty to develop the actual working plan for the state which included acute care, rehabilitation, and congregate living facilities. Several of us worked with the Advisory Council in 1975 and 1976 to develop this plan. As a result of the plan, 10 acute care centers were established throughout the state. We felt very early that these centers should have preventive efforts as an important part of their mission. As a designated acute care center, we developed a prevention program in Northwest Florida that was later adopted by the State Advisory Council and duplicated throughout the other eight districts in the state. The initial program was basically an education program to heighten the students' awareness of spinal cord injury prevention on an annual basis with classroom presentation: posters and brochures and follow-up reinforcement efforts.

The school program consisted of an initial talk defining the causes of spinal cord injury. A film entitled "Consequences" was then shown. This was followed by a short first aid demonstration by paramedics and then a personal account of a spinal cord injury from an injured person. The education program lasted 50 minutes and was given to 10th grade students in a classroom setting. In the first 5 years of implementation, it was estimated that over 60,000 students received the educational course.

The other major component of the initial Florida prevention pro-

gram was a public awareness campaign highlighting the cause of spinal cord injury. Since 1981, this campaign has highlighted the "Feet First First Time" program in an effort to reduce the most preventable cause of spinal cord injury, which is diving (Figure 1). This message encourages individuals to enter the water feet first and check the depth before diving. Many of the diving accidents occur in lakes, ponds, and rivers where tides and water depth constantly change. The "Feet First First Time" campaign was carried out throughout the State of Florida with the help of other centers. The logo began to appear on sun visors, bumper stickers, buttons, balloons, tote bags, etc. and was delivered statewide through public service announcements, television interviews, newspapers, magazine articles, health fairs, billboards, transit advertising, and civic group presentations. Signs were made by the Rotary Club and were placed by the Boy Scouts on all hazardous swimming areas throughout Northwest Florida, as well as in other districts in Florida (Figure 2).

In 1983, we were asked to exhibit at the annual meeting of the Congress of Neurological Surgeons in New York. As a result of that exhibit and discussions with the Executive Committee of the Congress, we received endorsement of the "Feet First First Time" program from the AANS and CNS. A brochure was developed so that others might replicate the program. Over 750 brochures were requested from neurosurgeons throughout the country and 20 different "Feet First First Time" programs were started in other communities with varying degrees of success.

We have continued to carry on our annual educational program in the schools. Our prevention program has been adopted by the State Advisory Council and has been duplicated in other districts within the state. Governor Bob Graham declared April as Spinal Cord Injury Awareness Month. We have used the wheelchair obstacle course designed by the Missouri group to gain legislative attention. We are working with the State Department of

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**In 1986, U.S. Surgeon General Dr. C. Everett Koop, with national media coverage, announced his support and encouragement for the National Head and Spinal Cord Injury Prevention Program and made his first significant public announcement concerning the public health problem of injury in the United States.**

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Transportation and Department of Education to make the school program mandatory in all schools throughout the state. We are helping other groups support legislation to enforce automobile restraint systems and toughen drunk driving laws and are involved in other activities to reduce the incidence of injuries to the head and spinal cord.

Along with the success of the "Feet First First Time" program in Florida, all the designated centers, including ours, are continuing to target the leading cause of spinal cord injury which is motor vehicle accidents. We also supported legislation, passed in 1987, creating a registry and care plans for head injuries. An advisory council for head injuries is patterned after the Spinal Cord Injury Advisory Council, and acute care centers for head injury are now being designated in the state. Since the inception of the national program in 1986, we have included head injury prevention as part of the Spinal Cord Injury Prevention Program and have enlisted the aid of the State Head Injury Foundation as well as others for the dissemination of this Program.



**One of the major accomplishments of the Program to date has been the production of the film "Harm's Way," which depicts the youth risk-taking behavior that led to head and spinal cord injury and the consequences of those injuries.**

#### *The Missouri Program*

In 1977, the University of Missouri School of Medicine received federal funding for the development of a Research and Demonstration Project for the rehabilitation of spinal cord injuries. The co-directors of that Program were Charles Peterson, M.D., Chairman of the Department of Physical Medicine, and Clark Watts, M.D., Chief of the Division of Neurosurgery. Research under the auspices of this project revealed that the incidence of spinal cord injury in central Missouri closely paralleled that seen nationally, with young people over represented. Stimulated by these data, the etiology of the injuries was analyzed. The results led the investigators to conclude that risk-taking behavior amenable to alteration by education was the major cause for these injuries. An educational program was designed and implemented in a few of the public school systems in the central Missouri area in 1980. The following year it was expanded to more school systems when preliminary data suggested that the program significantly improved the knowledge of young people regarding the origin and consequences of spinal cord injuries and altered their attitudes toward risk-taking behavior.<sup>3</sup>

When federal funding for the Demonstration Project expired in 1982, the offices for this educational effort were moved from the

Department of Physical Medicine and Rehabilitation into the Division of Neurosurgery. Shortly thereafter, because the literature revealed the etiologies for head injuries were the same as for spinal cord injuries, information regarding head injuries<sup>2</sup> was incorporated into the Program. The program was restructured and formally introduced as the Missouri Head and Spinal Cord Injury Prevention Program.

without disabilities from injury who can successfully capture and maintain attention of the students throughout the program which lasts approximately 1 hour. While this program began slowly, Table 1 illustrates the rapid growth of the program throughout the state in terms of schools visited and the number of students exposed per year. By comparing our budget with the number of students exposed,

**TABLE 1 — Missouri Head and Spinal Cord Injury Prevention Program, 1980 to Spring 1988**

<i>Year</i>	<i>Number of Students</i>	<i>Number of Schools</i>
1980	3,285	5
1981	2,244	7
1982	7,724	12
1983	8,022	11
1984	16,325	38
1985	22,572	56
1986	21,390	59
1987	17,869	39
1988 (Spring)	10,107	32
<b>TOTAL</b>	<b>109,538</b>	<b>259</b>

**T**he Missouri Program has remained the same since that time. It is composed of four components. The first is a basic education program taken to junior high school students through the public and private school systems. It is presented in assembly (Figure 3), with audiences as large as 2400 students. In a series of segments, basic information about the anatomy of the brain and spinal cord and the pathophysiology of injury are presented. The consequences of head and spinal cord injury are presented through the use of a film and also by testimony of a young individual who has survived a head or spinal cord injury. Paramedics present basic information on safe bystander behavior should students witness accidents and, finally, select students are presented an opportunity to negotiate an obstacle course in a wheelchair in order to reinforce sensitivities regarding disabilities. The faculty for this program consists of young, charismatic, articulate people with and

we estimate that the program costs about \$2.50 per student per year to deliver.

We provide school officials and community leaders with ideas for reinforcement of the experience for the young people once the program is completed. As a result, a number of safety clubs have been established in schools throughout the state of Missouri. Another component is public education accomplished through the use of public service announcements for television and poster information incorporated in some of the state and national parks throughout the state.

**A**n outgrowth of the program has been an extensively expanded participation in the state political process to affect policy change through legislation and agency decisions. The office of the Division of Neurosurgery at the University of Missouri School of Medicine has increasingly been asked to serve as a clearinghouse for information about head and spinal



cord injuries for a number of agencies in the state, including the Department of Health, for legislators grappling with such issues as attempts to repeal the seat belt and helmet laws and for a committee whose responsibility it is to advise the Governor of Missouri on head and spinal cord injury, the Missouri Head Injury Advisory Council.

In keeping with the call of the *Injury in America* report to study the efficacy of prevention programs, we have in place a number of projects designed to evaluate this effort. Because of lack of funding we have not, at this writing, been able to undertake an extensive efficacy study of incidence of injury and outcome. Rather, we have progressed more deliberately in an attempt to determine whether the program affects attitude and behavior. Follow-up studies to the original work in 1981 confirm that knowledge and attitudes are improved.

One important unpublished study we have recently completed indicates that several years after exposure, risk-taking attitudes of 445 students were favorably modified compared to a similar group of 379 students not exposed to the program. Through use of questionnaires and interviews it was significant that students in the exposed group reported more frequent use of seat belts, a stronger belief that seat belts were important to their safety, a lower likelihood of riding in automobiles with friends who had been drinking, greater awareness of the age group most likely to be injured, an increased knowledge that individuals can prevent spinal cord injury, and fewer accidents. Some of the projects which have grown out of this effort include an examination of the recidivism rate of young traffic offenders with the cooperation of a local Circuit Court Judge and the Department of Highway Safety, an analysis of public attitudes toward seat belt and helmet use, and the impact law enforcement officials have upon the public as educators of highway safety issues, the latter three efforts in collaboration with the School of Journalism at the University of Missouri.

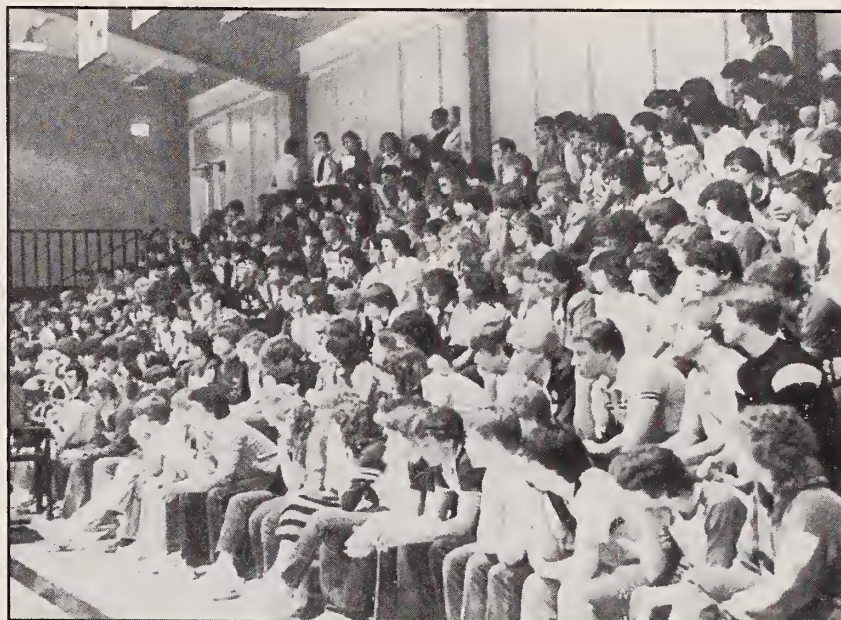


Figure 3 — The Missouri Program is presented in assembly.

### The National Program

#### *Development*

Following the charge from the leadership of the AANS and CNS, the co-directors of the national program, Drs. E. Fletcher Eyster and Clark Watts, held a series of meetings in the spring of 1986 to develop a National Head and Spinal Cord Injury Prevention Program. Its agenda, based on an initial 3 years of commitment of support by AANS and CNS, was divided into two avenues of development. Implementation of the Program followed the development of material which permitted interested and committed neurosurgeons throughout the country to begin public education programs within the various states, consisting of a youth oriented program, a reinforcement and public education program, and a program to influence governmental policy. It was recognized, however, that because of the magnitude of the problem, neurosurgeons alone would not be able to make a substantial impact upon public awareness, and an expansion effort was developed to permit involvement of groups of both lay and professional people outside of neurosurgery to influence public policy.

Educational and promotional material was developed to begin implementation. A syllabus was written which served as the text-

book to be used by the two groups to train individuals who visited the two programs. The syllabus included instructions on how to conduct the school program, ideas for reinforcement and public education projects, ways to interact with legislatures and governmental agencies, and advice on funding. Initial training of the interested groups began in the late spring and summer of 1986. In the fall of 1986 during the annual meeting of the Congress of Neurological Surgeons, the Surgeon General of the United States, Dr. C. Everett Koop, appeared in New Orleans and with national media coverage announced his support and encouragement for the National Head and Spinal Cord Injury Prevention Program and used the opportunity to make his first significant public announcement concerning the public health problem of injury in the United States.

Coincident with the implementation program, the expansion effort was also immediately put into place. A number of projects with other organizations and groups have been undertaken, too many to be addressed in detail in this paper. However, some examples will be described, illustratively, to indicate the wide nature of this aspect of the program.



The National Park Service expressed a concern over the mounting injuries related to land and water traffic in its jurisdiction and requested input from the National Program. Youth-oriented public education demonstration programs were subsequently presented in districts of the National Park Service covering the Ozark National Scenic Riverway and the Lake Mead area in Nevada. Both the National Head Injury Foundation and the National Spinal Cord Injury Association have requested and received advice concerning public education. The National Head and Spinal Cord Injury Prevention Program helped sponsor, with the American Medical Association, a conference on unintentional injuries of adolescents in Chicago in the fall of 1987. The AANS and CNS, co-sponsors of the National Head and Spinal Cord Injury Prevention Program, have joined with the American Academy of Pediatrics and 50 other organizations to increase the awareness of the public and public officials of injuries to children 14 and under, a program also endorsed by Dr. Koop, "Safe Kids."

The Co-Directors of the Program have worked very closely with the Washington Committee to help affect funding for the development of a trauma registry by the Centers for Disease Control and also for the passage of emergency medical service and other trauma-related legislation in Congress.

One of the major accomplishments of the Program to date has been the production of the film "Harm's Way" by film maker Barry Corbet. This 18-minute film depicts, through a series of interviews of young people who have survived head and spinal cord injuries and who were, for the most part, former patients at the University of Missouri-Columbia Health Sciences Center, the youth risk-taking behavior that led to injury, and the consequences of those injuries. The film has won a number of national awards, including: Blue Ribbon Winner in the 1988 American Film and Video Festival, Gold Circle Award from the American Society of Association Executives, First Place Golden Camera Award from

the U.S. Industrial Film Festival, and the Golden Eagle Award of the Council on International Non-Theatrical Events. It has been widely distributed throughout the United States and Canada. A shorter version of the film, entitled "Reflections," has been produced for use within the neurosurgical community as an option to "Harm's Way," depending on local needs.

Our most recent major step is the naming, in the spring of 1988, of a national coordinator, Louise Miller, who will help coordinate, from the office of the AANS in Chicago, what undoubtedly will be continued growth in the Program. To provide an expanded base of advice and direction for the national coordinator, the leadership of the AANS and CNS created, in the fall of 1988, an Advisory Council consisting of the two co-directors and a representative from each governing board of the two major neurosurgical societies.

The National Head and Spinal Cord Injury Prevention Program has been well established, with a number of mature local programs across the country. As of this writing, there are 115 groups that have visited either Missouri or Florida for training, and there are 97 programs that are actively conducting prevention projects in 47 states as well as the District of Columbia and Canada. Some have expressed satisfaction in their efforts and believe and hope they are being effective.<sup>4</sup> Neuwelt has data that indicate the program in Oregon improved knowledge and altered attitudes regarding head and spinal cord injuries and their relationship to risk taking.<sup>5</sup>

### The Future

Without a doubt, implementation will continue to increase the number of programs directed by neurosurgeons in this country aimed at public education, especially the education of young people in the public schools. The Joint Council of State Neurosurgical Societies, during the April, 1988, Annual Meeting of the American Association of Neurological Surgeons, took initial steps to become more formally involved in the coordination of various state activities. This will allow

the development of a statewide coalition. It would also permit the development of larger numbers of primary training sites distributed uniformly through the United States to increase the implementation effort. Annually, workshops are being held at the American Association of Neurological Surgeons meeting so that groups may share their experience with involvement of implementation of these programs. Through the Joint Council and the national coordinator, more extensive exchange of ideas will occur. This will help develop a uniform policy position among the states regarding injury control and also provide an expanded pool of insight into innovative funding sources, which, to date, have generated almost two million dollars in support of the local efforts.

In the expansion effort, neurosurgeons, together with their physician colleagues, must continue to provide leadership in the analysis of current public policy and recommendations for change in that policy. For example, very little funding is currently available for research in injury, whether it be prevention, management, or rehabilitation. A major goal of this program should be to effect a manifold increase in NIH and other funding for injury research.

The National Head and Spinal Cord Injury Prevention Program provides the medical community with a means to educate the public at large on the importance of the social and economic consequences of neurological injuries. At the same time, it provides a program which encourages a safer lifestyle in our own communities, especially among those at greatest risk — young people.

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# Head Injury at the Southeastern Georgia Regional Trauma Center: A Three-Year Review

Carl R. Boyd, M.D., Charles H. Usher, M.D., Fremont P. Wirth, M.D., Edward F. Downing, M.D., Roy P. Baker, M.D., Cliff L. Cannon, M.D., Kathleen M. Corse, C.C.R.N.

## Introduction

**T**RAUMATIC INJURY continues to be the number one cause of death in persons under the age of 45 in the United States. Head injury is a major contributor to mortality due to trauma. Estimates of the incidence of head injury range from 152/100,000 to 295/100,000.<sup>1-4</sup> Mortality from head injury has been reported to range between 7.5% and 17%.<sup>1,3,5</sup> Neurosurgical capability and availability are essential components to any organized system of trauma care delivery. Because of the limited capabilities of some hospitals to deliver neurosurgical care, particularly in a rural area, neurosurgery is one of the major elements a trauma center offers to its regional system of care.

This 3-year retrospective review of patients with head injury admitted to our Regional Trauma Center was undertaken to identify the epidemiological factors associated with head injury in our patient population and to evaluate the impact of head injury on a trauma center within a rural system of trauma care.

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**This review was undertaken to identify the epidemiologic factors associated with head injury in our patient population and to evaluate the impact of head injury on a rural system of trauma care.**

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As a part of this evaluation, mortality from head injury at our trauma center was reviewed.

## Methods

Trauma registry data for consecutive admissions was reviewed for the 3-year time period of July 1985 through July 1988. Only those patients with a Head Abbreviated In-

jury Score (HAIS) of 2 or greater were included in this review.<sup>6</sup> Data points evaluated included sex, age, mode of injury, mechanism of injury, Glasgow Coma Score (GCS), Abbreviated Injury Score (AIS), Injury Severity Score (ISS), Trauma Score (TS), calculated probability of survival (Ps), origin of admission, type of prehospital transport, need for operative intervention, associated extracranial injury (ECI), service of admission, intensive care utilization, and length of stay.<sup>6-8, 11</sup> Mortality rates based on HAIS and GCS were calculated and compared to recent data from the trauma literature. Table 1 describes the calculation of the head section of the Abbreviated Injury Score.

Patients were excluded only if they were pronounced dead on arrival to the emergency department and no resuscitative attempt was made.

Patient groups were defined as follows: Group A was all patients in the study; Group B was only those patients with severe head injury (HAIS  $\geq 3$ ) and no major extracranial injury (ECI AIS of  $\leq 2$ ); and

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Send reprint requests to Dr. Carl Boyd, Director, Trauma Service, Memorial Medical Center, Inc., 4750 Waters Ave., Ste. 213, Savannah, GA 31404.

Group C was those patients with any level of head injury and no ECI.

Results

During the time period of the review, 3310 patients were admitted for trauma. Of those, 852 (26%) met the inclusion criteria for head injury. There were 599 males (70%) and 253 females (30%). The average age was 28, and 25% of all patients were 14 years of age or

tors of overall injury severity include an average TS of 12, mean ISS of 22, mean Ps of .743. A total of 492 patients (58%) required admission to an intensive care unit. The average length of stay in the hospital was 17 days and, on the average, 5 days were spent in an intensive care unit.

Evaluation of point of origin of admission revealed that 48% of admissions were for patients injured in our local area (Chatham County). There were 516 (52%) patients

Region IX, with 81 of these transfers occurring from southernmost South Carolina. Sixty-three percent were transferred by ambulance EMS, 22% were brought by our hospital based helicopter EMS (Lifestar), and 14% of patients were brought to the emergency department by a privately owned vehicle. During the time period of the study, 463 (55%) patients were admitted to Neurosurgery, 213 (25%) were admitted to the Trauma Service, and 113 (13%) were admitted to Orthope-

TABLE 1 — Head Abbreviated Injury Score — Baker et al, 1985 Revision

1 Minor	2 Moderate	3 Severe, Not Life Threatening	4 Severe, Life Threatening	5 Critical, Survival Uncertain	6 Maximum Injury
Headache/ Dizziness	Amnesia Lethargy LOC <1 hr Vault Fx	LOC 1-6 hr LOC <1 hr with deficit Basilar Skull fx Comminuted/ compound/ depressed vault fx Cerebral contusion Subarachnoid hemorrhage	LOC 1-6 hr with deficit LOC 6-24 hr Fx skull >2cm Torn dura Tissue loss Intracranial hematoma ≤100cc	LOC with inappropriate movement LOC >24 hr Brain stem injury Intracranial hematoma >100cc	Brain stem crush/ lac Crush fx Decapitation

TABLE 2 — Mechanism of Injury

	Number	Percent
A. Blunt		
Motor Vehicle Accident	341	41.0
Fall	179	21.5
Pedestrian	104	12.5
Assault	59	7.0
Motorcycle	44	5.3
Total	727	87.3
B. Penetrating		
Gunshot Wound	48	5.8
Stab Wound	2	0.2
Total	50	6.0
C. Other	56	6.7
Total	833	100.0

younger. Eighty-seven percent had suffered blunt trauma, while 6% were admitted for gunshot wound or stabbing. The breakdown of head injury admissions by mechanism of injury is shown in Table 2. Indica-

TABLE 3 — Frequency of  
Glasgow Coma Scores

GCS	Number	Percent
3	90	11.7
4	30	3.9
5	10	1.3
6	36	4.7
7	35	4.6
8	22	2.9
9	17	2.2
10	14	1.8
11	18	2.3
12	15	2.0
13	31	4.0
14	51	6.6
15	400	52.0
Total	769*	100.0

\* Of 852 patients, 769 had a recorded GCS.

transferred to the trauma center from outlying counties. A total of 319 were transferred from within the 24 counties that make up Region IX EMS in southeastern Georgia, and 113 were transferred from outside

edics, Plastic Surgery or another surgical service.

A total of 409 patients (48%) required operative intervention: 137 had neurosurgical intervention (16%), 232 (27%) had operative intervention other than neurosurgical, while 39 patients required combined procedures.

A description of the frequency of GCS on admission is presented in Table 3. The average GCS for the total group (Group A) was 10. Thirty-eight percent of all admissions had minor or moderate injury (HAIS ≤2) and 62% of all admissions had major head injury (HAIS 3-6). A total of 791 patients had some associated injury, with extremity injury being the most common (34%), followed by chest injury (24%), facial injury (23%), and abdominal injury (10%). There were 292 patients (34%) with severe head injury defined by a HAIS of 3 or greater and no ECI other than minor (ECI AIS of 2 or <) (Group B).

One hundred and twenty-one patients died, for an overall mortality



rate of 14%. In the pediatric age group, the overall mortality was 8.8% (Table 4). For the 292 patients in Group B, there were 48 deaths, giving an overall mortality rate of 16.4%. For the 359 patients in Group C, there were 44 deaths, for a mor-

TABLE 4 — Pediatric Head Injuries*	
Pediatric Patients With:	Number
Head Injury	216
Isolated Head Injury	140
Severe Head Injury†	81
Total Deaths	19
Percent Mortality	8.79
* ≤ 14 years of age	
† HAIS ≥3	

tality rate of 12.2%. A breakdown of mortality for patients groups based on admission GCS is listed in Table 5.

Mortality based on Head AIS for the different patient groups is shown in Table 6.

Discussion

The impact of head injury on the trauma center is readily apparent since 26% of all trauma admissions in the past 3 years had head injury as a component of their injuries sustained. A total of 58% of all patients required ICU admission and utilized some 825 ICU patient days per year, which makes a great impact on ICU resources. The total number of hospital days utilized was 4828 per year. One hundred and thirty-seven (16%) of these patients required operative neurosurgical intervention, of course impacting significantly on operating room resources which is often manifest outside of normal work hours.

The large percentage (52%) of all head injury admissions originating outside our local area has clear implications on the impact of head injury as a part of a regional system of trauma care. For all trauma admissions in 1988, 40% originated outside our local area, and this number includes the head injured.

These observations have obvious implications for the planning and maintenance of a regional system of trauma care. Therefore, head injury is a major reason for transfer to a regional trauma center. Since we operate in a rural system, it is not surprising that approximately one out of four reach the trauma center via helicopter transport.

Evaluation of outcome for neurosurgical patients should include some objective measure of functional ability post discharge. This review does not include such a

studies do not define strict inclusion criteria or account for the confounding variable of level of head injury severity based on objective standards, direct comparison of mortality rates is limited at best.

When our mortality rates are compared to the study by Rozycki et al<sup>9</sup> using GCS groups, our mortality rates were very similar within the groupings and suggest that outcome in our patient population equals contemporary survival curves based on GCS. Interestingly, comparison of mortality between

TABLE 5 — Mortality Based on Glasgow Coma Scale				
GCS	All Patients (Group A)		Severe Head Injury* (Group B)	
	Number	Mortality %	Number	Mortality %
3	90	74.4	38	81.6
4-5	40	45.0	20	40.0
6-8	93	18.3	31	19.4
9-12	64	6.2	26	0.0
13-15	482	1.9	154	1.9
Total	769†	14.9	269	17.8
* HAIS ≥3 and extracranial AIS ≤2				
† Of 852 patients, 769 had a recorded GCS				

TABLE 6 — Mortality Based on Head Abbreviated Injury Scale						
HAIS	All Head Injuries (Group A) N = 843		Severe Head Injuries* With Non-Severe Other Body Injury (Group B) N = 292		Pure Head (Group C) N = 359	
	Number	% Mortality	Number	% Mortality	Number	% Mortality
2	318	0.0	—	—	151	0.0
3	196	5.1	112	0.9	75	0.0
4	134	3.7	87	2.3	60	3.4
5	165	42.4	72	34.7	52	40.4
6	30	100.0	21	100.0	21	100.0
* HAIS ≥3 with extracranial AIS ≤2						

measure, as our primary purpose was to review the ultimate outcome of mortality. Currently, our rehabilitation medicine program is evaluating the functional outcome of patients admitted for trauma.

The overall mortality in this series compares very favorably with previously published reports. Overall mortality rates, however, can be misleading. Because most previous

Group A (all patients) and Group B (severe head injury with minor extracranial injury) showed no obvious differences. This implies that mortality from head injury is predicted by GCS and the head injury component, and is relatively insensitive to level of extracranial injury.

When we compared mortality for head injury based on anatomical severity as indicated by HAIS group-

**The large percentage (52%) of all head injury admissions originating outside our local area has clear implications on the impact of head injury as a part of a regional system of trauma care.**

ings, the comparison also suggested the mortality rate was affected by the level of head injury and relatively unaffected by the presence of extracranial injury. This finding is similar to those of Genarelli et al<sup>10</sup> who reported on data from the Major Trauma Outcome Study on 16,524 patients with head injury. In that study, an ECI AIS of

4-6 did influence survival in the head injured. We did not separate our data in this manner, and therefore cannot compare the effect of severe extracranial injury on head injury in our population to that study.

### Summary

The impact of head injury on our trauma center is significant because of the large number of cases with their heavy utilization of trauma center resources. Head injury also exerts a major influence on the Trauma Center in a rural area since it serves as a major provider of care for the head injured over a wide geographical area. Mortality rates seen in this population compare favorably with contemporary data from other studies using GCS and Head AIS as indicators of level of injury.

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# MAG Responds to Medicare Morass in Georgia

Joseph P. Bailey, Jr., M.D.

**T**HE CONTINUING PROBLEMS associated with the Medicare reimbursement morass in Georgia recently drew representatives of the Medical Association of Georgia to Washington, D.C., to meet with government and Medicare carrier representatives. On April 19, 1989, MAG President Joseph P. Bailey, M.D., MAG Executive Director Paul Shanor, and MAG Director of Medical Practice Cam Taylor met with the six members of the Georgia Congressional Delegation, including U.S. Representatives J. Roy Rowland, Buddy Darden, Ben Jones, Doug Bernard, Lindsay Thomas, and Charles Hatcher, as well as staff representatives of those congressmen not present. Others attending included Louis Hayes, Acting Administrator, and Barbara Gagle, Director, Program Operations, Health Care Financing Administration (HCFA), Washington, D.C.; George Holland, Regional Administrator, and Richard L. Warren, Associate Regional Administrator, Region IV, HCFA, Atlanta; Robert Champagne,

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**The status quo of the Georgia Medicare system is, in the judgment of MAG, no longer tenable.**

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*Director, Part B, Medicare Operations, Aetna, Hartford, CT. Susan A. Stallings, Georgia Medicare Program, Savannah; Robert J. Becker, M.D., Chairman, and Alan Korn, M.D., Medical Director, HealthCare COMPARE Corporation, Chicago. Dr. Bailey made a lengthy statement at that meeting. The following article constitutes most of his remarks. (For the complete statement, contact Cam Taylor, 404-876-7535 or 800-282-0224.)*

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This article represents the majority of a statement by Dr. Bailey, the 1988-89 President of MAG, made to the Georgia Congressional Delegation as well as to other government and Medicare carrier representatives in Washington, D.C., on April 19, 1989.

**G**entlemen,

At your request, the Medical Association of Georgia has assessed information on Medicare payments and related administrative services provided to physicians and their patients by the Aetna Life Insurance Company and the HealthCare Compare Corporation following the transfer of Medicare carriers from The Prudential Company in November-December, 1988. This report provides a summary of the reasons why MAG feels the present reimbursement program is not operating satisfactorily and is, in fact, posing a potentially serious barrier to the provision of needed medical services to Medicare patients in Georgia and to the reimbursement for those services to physicians and their patients.

## **Background**

In June, 1988, the Health Care Financing Administration (HCFA) contracted with the Aetna Life Insurance Company and its subcontractor, the HealthCare Compare

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**This report provides a summary of the reasons why MAG feels the present reimbursement program is not operating satisfactorily and is, in fact, posing a potentially serious barrier to the provision of needed medical services to Medicare patients in Georgia and to the reimbursement for those services to physicians and their patients.**

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Corporation, to administer the Medicare program in Georgia beginning on January 1, 1989. As a condition of this contract, HCFA required that Aetna contract with a private utilization review company to carry out its medical utilization and "necessity" reviews. Georgia's program was later identified as being a part of a special nationwide research project being conducted with several other control states — Equicor of North Carolina, Aetna of Arizona, Indiana Blue Shield, and Louisiana by Arkansas Blue Shield to evaluate the effectiveness of independent utilization review company reviews versus those done by the carrier. Georgia's so called "flexible" carrier would be given additional latitude and funding to develop their utilization review component in whatever creative way they desired — with no constraints added. If desired, they also would be given the opportunity to drop the 13 mandatory review screens currently required by HCFA. This, in turn, would be compared to the "flexible" carrier and "control" states to see if improvements would occur in utilization management and cost control.

Prior to this time, the Prudential Insurance Company of America had been the Medicare Part B carrier since 1966, 2 years following the Medicare's program inception in 1964. The change in carriers reportedly had occurred as a result of a recent decline in carrier performance evaluation reports made by HCFA and because of Prudential's belief that the program was inadequately funded. No evaluation was asked from the physicians or patients in the program, and the change was presumably related to a lack of "good results" from the carrier. Although increasing federal legislative constraints had added to the program's complexity, its overall operation appeared to be generally satisfactory to the majority of Georgia physicians.

During the June to January pre-start-up period, a number of tactical planning sessions were held by the carriers and the HCFA Region IV office. MAG met with Aetna officials on at least two occasions and were also assisted by Aetna and HealthCare Compare in a series of Medicare Law Workshops conducted for physicians by MAG. From January to the present, MAG has met with both Aetna and HealthCare Compare officials on several occasions to attempt correction of multiple difficulties being encountered. In spite of these efforts, the Medicare carrier conversion in Georgia began its "Day One" with an incredible number of difficulties and continues as of this date to have major flaws in its operation. The status quo of the Georgia Medicare system is, in the judgment of MAG, no longer tenable. Major elements of these problems are outlined below:

**Inordinate delays in the payment of patient claims and inaccuracies in payment amounts to physicians and their patients.**

Aetna's backlog of pending claims rose from 580,000 claims pending in January, 1989, to over 800,000 claims by the end of February. As of March 28, the pending claims were again reduced to only about 583,000 — the normal amount being about 300,000 claims.

Many physicians continue to report delays in claims payments originating from those submitted in November and December, 1988, and in amounts up to 60-80% of accounts receivable. For payments that are received, high error rates and payment inconsistencies are rampant.

**Significant errors in the general processing of patient claims.**

The administrative processing of Medicare claims, both in electronic media claims and paper claims have been fraught, systemwide, with a multiplicity of procedural and policy errors. Physicians and patients report repeated instances of mis-coding, downcoding, erroneous and/or incomplete service entries, inaccurate data transfers, and a blight of physician identification, and patient identification errors. A clear understanding of the exact reason and nature of these persistent problems has not been forthcoming.

In terms of the Electronic claims system, it has virtually drawn to a standstill because of its failure to accurately balance remittance tapes. Aetna also does not confirm that the claim has been received, causing many omissions to go unnoticed.

**The absence of adequate and timely instructional communications on New Medicare laws and regulations, conversion problems, and policy changes.**

Aetna letters of communication have been extremely sparse and when sent were usually late and contained inaccurate information on key events. For example, the 1989 Medicare Participation Letter and Maximum Allowable Actual Charge (MAAC) data arrived in many physicians offices in Georgia in late December and early January for a December 31, decision deadline. Numerous physicians also failed to receive their MAAC levels with the letter. If the information was received, it was often inaccurate and resulted in physicians not knowing what they would be allowed to charge for their patients in 1989.

Aetna newsletters dated for Feb-



ruary were actually received in March. Erroneous January 1 start up dates were given for new important federal provisions covering Radiology and Anesthesiology fee schedules, which were actually delayed until April 1. Further, physicians were sent policy statements in April for utilization screens that actually began on January 1. During this conversion period, neither HCFA, nor Aetna offered physicians an update of developments or possible solutions for the litany of complaints made.

**The absence of an effective telephone and general communication response mechanism.**

Aetna has an automated inquiry system (INFOBOT) that responds to status inquiries and, through a selection process, connects incoming callers with an operator. The excessive payment delays and subsequent errors in processing has generated extremely high numbers of telephone calls and inquiries. Aetna provides a toll-free 800 number for beneficiaries and participating physicians, while on the other hand, requires non-participating physicians to use commercial lines. Physicians and patients continue to report consistent delays of more than 15 to 45 minutes for responses. They also report that Aetna operators routinely do not know answers to the questions posed and follow-up calls are rarely received.

Responses to correspondence is even worse. There is a 30-45 day delay at this time. Physicians report that they either receive no response or the response is often unclear or inappropriate. Aetna's delay in reviewing correspondence has also resulted in unnecessary denial of some claims since they must occur within a 45 day period.

**The introduction of a new set of Utilization Review/Medical Necessity policies which are arbitrary and capricious and are in conflict with accepted patterns of medical treatment.**

The involvement of a utilization management firm unfamiliar with the complexity of the Medicare pro-

gram has added to the problems of carriers conversion. Confusion exists as to whether some of the problems are associated with directions from HCFA, Aetna processing, or HealthCare Compare initiatives.

There are four major problem areas which appear to be due, in part, to stringently applied utilization controls:

*1. Comprehensive Services*

A major difficulty has been the problem of the automatic denial or downcoding of almost all claims for comprehensive services. MAG feels it is totally inappropriate to automatically downcode or change any procedure code without first contacting the physician for additional information.

If individual physician profiles indicate possible abuse, we feel this should be adjudicated on a case by case basis. Physicians have also been instructed to provide documentation for every comprehensive service billed.

*2. Concurrent Care*

As discussed earlier, multiple denials have been issued for the second physician submitting a claim when more than one physician is involved in the on-going treatment of a patient. This is in total contradiction to good medical practice patterns and again disrupts the needed treatment and care for the Medicare patient.

*3. Consultations*

Precipitously, HCC instituted a strict interpretation of the CPT definition for consultation. This is resulting in automatic denials and downcodings for many consultations, regardless of the patient's condition. Further, if the patient history indicates a physician has billed for one consultation, a follow-up consultation is automatically downcoded to a lesser category and paid at that level. This we feel, is an inappropriate interference with the physician-patient relationship and of the physician's judgment of what level of medical treatment is needed.

*4. Medical Necessity*

The present review program instituted by HCC has also failed to follow the guidelines concerning "claims development" when look-

ing at the "medical necessity" for services. Services continue to be denied without first notifying the physician that there is a question of the medical necessity for the care. Patients are given the impression, then, that they may have been treated unnecessarily and charged more than was appropriate. This has severely strained the trusting relationship between patients and their physicians. Again, massive amounts of documentation are being required for even the most routine of services — patient history, laboratory results, etc. In most cases, the information appears to make little difference in the claim decision.

**Conclusion**

Up to now, Georgia physicians have shown a very strong commitment to our state's elderly citizens through their high participation in the Georgia Medicare program. In 1988, some 8950 physicians were enrolled in the program, with patient claims made on an assignment basis at a rate of 76.8% — that is, claims in which the physician was willing to accept Medicare's "approved" amount as the payment in full. Recent events concerning the carrier conversion have brought a serious schism in the Part B program in Georgia and raised the question of whether it can successfully continue.

MAG urges that immediate efforts be taken to ensure that Medicare pays for physicians services in a manner that ensures patient access to needed medical services and maintains fiscal responsibility by patients, physicians, and the federal government. Several immediate steps that we feel should be taken include:

1. A thorough and immediate review of present computer edits and screening policies used by Aetna and HealthCare Compare for their claims processing and utilization review decisions. In the interim, an immediate elimination should be made of all automatic and arbitrary downcodings and/or service denials of comprehensive service codes.

2. Installation of a toll-free line and accessible communication

system for all physicians enrolled in the Medicare program, particularly during the first year phase in period.

3. Selection of a special consultation management team to assist in the analysis of operational problems and staff training. MAG should be a part of this management team.

4. A revision of the Explanation of Medicare Benefits (EOMB) which correctly reflects individual service and interest payments.

5. An evaluation of the electronic media claim system to determine accounting deficiency problems.

It is the position of MAG that some of the problems mentioned are occurring not as a result of mistakes but as a result of a carefully crafted scenario to reduce Medicare payments through perceived incompetence. It should be noted by the Georgia delegation that we have yet to uncover a single incident of *overpayment*, *upcoding*, or payment for services *not* rendered. Were the problem in truth one of mistake and incompetence, errors would occur both in favor of — as well as against — the physician or patient. Finally, a system dedicated to the

care of a country's aging citizens whose increased age has been made possible in part by the medical profession's ability is being subverted by an organization employed to support this very system. This same organization (Aetna) has contracted with a utilization review organization (HealthCare Compare) which is dedicated to demonstrating its own cost effectiveness and not that of the system. Correction of this situation is fundamental to the well being of a major segment of America's population.

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# Making A Difference — One Woman's Involvement

Bo Shurling

**T**HE NAME LUCY CHEESMAN probably doesn't ring a bell. She is not a famous actress, a well-known politician, or the noted discoverer of a medical cure. But to the people she serves, she is more important than all of these people.

Ms. Cheesman, a retired nurse, helps the homeless and indigent by working in a soup kitchen at the Elizabeth Methodist Church in Marietta, Georgia.

She grew up in rural Virginia where her mother, though not a nurse, yet traveled around the community and cared for the sick. Two of her uncles and one of her grandfathers were doctors.

It is to these people and her life in the country that Ms. Cheesman attributes her feeling of public service and her understanding of the importance of putting her arm around her fellow human being when he or she is suffering.

She has proven that a person can make a difference in his or her corner of the world, and we thought you might enjoy reading about the ideas and actions of this opinionated and animated lady.

---

***"It's very important to have a sense of communication, not just through talking, but touching and putting your arms around someone."***

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**MAG:** How did the program at the Methodist Church get started?

**Mrs. Cheesman:** I had been trying to get St. James Episcopal Church to establish a soup kitchen. They kept pointing out all the reasons it wasn't possible. I accepted their reasons. But I still fixed sack lunches for anybody who came to St. James hungry, and they would eat their lunches out back.

Several churches in the area were doing what they could, and a great many of them felt it would be much better to have everything located centrally.

It was about 6 years ago when I got a call from the wife of a former minister of the Elizabeth Methodist Church who asked if I wanted to

help in the soup kitchen. I said sure. The first time we served food we had five cooks and only three guests.

We started with a government grant, but we found out that operating under federal guidelines was a little more than we could cope with. We had to fill out a slip for each guest that came to the kitchen, and we were supposed to ask them a great many personal questions.

We wanted to name the soup kitchen program Loaves and Fishes, and we wanted it to epitomize the concept of: let all who will, come and eat. We didn't want to make any restrictions at all and to do that we had to operate independently.

So, as soon as we spent all the money the government had given us in the initial stages, we let that drop.

**MAG:** If you are no longer receiving money from the government, where do you get food for the soup kitchen?

**Mrs. Cheesman:** We sent out the word to other churches that we needed the leftovers from their

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Mr. Shurling is a freelance writer in Atlanta as well as a feature writer with *the hudspeeth report*.



meals, and at that time we were only operating 2 days a week. Now, I think there are about 12 churches participating, and we are operating 5 days a week.

Some of the local fast food places also help us. They may have slaw that would run into its expiration date in 3 days, so they will send it to us. Sometimes it's a little difficult to get rid of 500 cups of slaw, but we usually manage.

Rich's and Macy's also help us by giving us loaves of bread.

Sometimes there are individuals who want to help those less fortunate, and they want to do something near home so they give us a contribution.

Recently one of our former guests came in, and he had managed to get on his feet a little bit. He came in and said, "I haven't had to eat here for about a week," then he gave me ten dollars. I guess that was his way of saying thanks.

It's very encouraging that so many people have latched on to this. Now we serve over 450 people a week.

**MAG:** What types of people make up the 450 the soup kitchen helps each week?

**Mrs. Cheesman:** We serve a lot of families and alcoholics. At first, I didn't think it was very good for the children, who were in pretty unstable environments anyway, to be around a bunch of vagrants. But we needed to take care of both of them. As time went on, I became pleasantly surprised. Our local vagrants were very careful with their language and behavior when they were around children.

We have a great many working poor. In the last 4 years we have seen more and more people who are working hard all day, every day, but still can't afford rent and food.

There are a lot of transients who have come to town looking for construction jobs. A lot of others are just passing through, and their car breaks down and they can't afford to get it fixed or to stay in a hotel.

If the funds are available, we put them up in a motel or help them get their car fixed. Sometimes it's



just a matter of letting them make a phone call so they can get help from family or friends back home.

We also see a great many people who have some form of addiction. But we have just as many addicted people in polite society. They just manage to cover it up a little better. My dear friends don't cover it up.

**MAG:** Why did you want to get involved with the poor, the homeless, the addicted, or people who some feel created their own mess and don't deserve help?

**Mrs. Cheesman:** I had retired from the hospital, and I was bored at home and didn't like housework

much. (She says smiling.) God has always helped me and never asked me if I deserved it. I think we need to see all humanity as our brothers and sisters, and if they have an addiction we need to realize that there but for the grace of God go I. You never know.

We are always praying, asking God to help people. When God has already commanded, not asked, us to feed the hungry, clothe the naked, care for the sick, and visit those in prison. Just sitting there praying for people isn't going to be very useful. We have to do something a little more tangible. That's the situation I have to face.





**MAG:** So you are not in the habit of making moral judgments?

**Mrs. Cheesman:** Oh, I don't make any judgments at all. What right do I or anybody else have to make judgments? You never know what somebody's been through by looking at them. You look at me and you would think I'm a nice old lady, wouldn't you? Well, I'm not!

**MAG:** Besides addictions, what are some of the other causes of people being indigent?

**Mrs. Cheesman:** I could probably list a thousand. Lack of low income

housing and lack of transportation are two that come to mind.

One of our guys had gotten out of jail and had been hired at a box factory in East Point. Everything was going O.K., then one day his car broke down, and he couldn't get to work, so he was fired.

What can we do?

Too many people don't want MARTA in Cobb County because we might get some undesirables from Atlanta. We have simply not caught up with reality.

As much as I don't like some aspects of unions, I think another problem is the lack of them in some areas. We have men that work out of labor pools. They stand on the

corner and some construction company will pick them up to work for a week. At the end of the week, they get one-third of the pay they were promised, and they have worked all week with no protection of health coverage.

Something needs to be done about babies having babies. These teenagers need to have counseling sessions so they can learn how to be mothers and how not to become mothers next time. We need to make sure that kids in school are learning to read and write.

**MAG:** Do you have any other suggestions for overcoming the problem?

**Mrs. Cheesman:** I would like to come up with the suggestion to solve all of life's problems, but I'm too realistic to think I can do that. I think President Bush's little points of light are fine, but they are not inexhaustible. More needs to be done by the government.

**MAG:** Why does it need to be the government?

**Mrs. Cheesman:** Certainly, not because they are the most efficient. By now you would think they would have the expertise to deal with this type of problem. Besides, if they are going to take tax money, then I think they should be involved.

**MAG:** What steps do you think government should take?

**Mrs. Cheesman:** The welfare state in Georgia is deplorable. A woman only receives enough aid to feed three-quarters of her children or a family doesn't get enough food stamps so they run out before the end of the month. That's when we see the greatest influx of people.

The Legislature has to pay closer attention to the needs of the whole state, not only in their districts.

As far as I'm concerned, the last thing they need to be spending money on is a dome for the Falcons. It's not going to help the Falcons, and the money could be used in a much better way.

When the Legislature does pass laws to help our needy citizens, they have to budget funds to support the





law. Otherwise, it is something you just as well not have. It just looks good on the books.

We need stronger laws to waive liability so more people have access to better health care.

**MAG:** Speaking of health care, what do you think the medical profession can do to improve the plight of the needy?

**Mrs. Cheesman:** The members of the medical profession who care are already doing what they can.

Socialized medicine is certainly not a pleasant prospect. I want to go to my own doctor, and I want a right to choose.

I don't think one hospital in a county as big as Cobb is the answer. We need a free-standing clinic approach. Nine times out of ten, most of our guest's medical needs can be taken care of with a little first aid. Sometimes it may be as simple as washing somebody's feet and getting them some new socks and shoes.

We need a place with a triage system or sort of like a "medical soup kitchen." A place where,

maybe not a doctor, but a nurse could take care of the smaller problems and then refer more serious cases to a doctor who has agreed to work in the clinic.

**MAG:** What about the religious community?

**Mrs. Cheesman:** Most people in the mainstream of Protestantism, Catholicism, and Judaism are concerned, are humanitarian, and most of them profess basically to the belief that we are our brother's keeper. I just think more people need to get involved. Like I said earlier, just praying won't get the job done. You've got to do something more tangible.

I don't know all the Bible verses about why you should help out. You do it because it's the right thing to do.

**MAG:** What can individuals do to help alleviate the problem?

**Mrs. Cheesman:** Lean hard on their legislators. People are not nearly politically involved as they should be. Then get involved by working

in a soup kitchen or shelter or some other aspect of solving the problem.

**MAG:** In closing, what would you like to say to people that may make them want to become a part of the solution to the problem of the indigent?

**Mrs. Cheesman:** People need food. Luckily for us we have the food, but we need hands to help serve it. We never run out of needs. The needs of our guests are overwhelming.

After helping these people for a while, it becomes deeper than just feeding so many people from 11:30 to 12:30. You get to know the people, and you become more sensitive to their needs as people and not just bellies to be filled.

Our guests have pride and you can't think in terms of "we and them." It's very important to have a sense of communication, not just through talking, but touching and putting your arm around someone.

**A**lso, like I said earlier, there but for the grace of God, go I.



## Endometrial Cancer — Diagnosis and Management

Mark A. Crozier, M.D.

**C**ANCER OF THE UTERUS is the most common gynecologic malignancy. The American Cancer Society estimates that 35,000 women will develop uterine cancer this year. Over the past 20 years, there has been an increase in the incidence of endometrial cancer. Several possible reasons for this include an aging population, increased availability of medical care, environmental and dietary factors, a broadening of the criteria for the diagnosis of endometrial cancer, and the increased use of estrogen replacement therapy in post-menopausal women. The average age of onset of endometrial cancer is 61 years, with the largest number of patients being between 50 and 60. Approximately 25% of the endometrial cancer patients are pre-menopausal.

### Risk Factors

The classic risk factors for endometrial cancer are obesity, multiparity, late menopause, diabetes, and hypertension. There is also a subset of younger obese women with oligomenorrhea who have a 12-fold risk of experiencing endometrial cancer. Because of an increased proportion of body fat, these women do not ovulate on a regular cyclic basis. This causes a persistent stimulation of the ovary by pituitary hormones. These hormones result in increased

levels of circulatory androgens, which are converted to estrogens in the peripheral adipose tissue. Thus, the uterus is exposed to continuous estrogen stimulation. This stimulation results in hyperplasia of the endometrium and ultimately endometrial carcinoma in some patients.

It has also been established that post-menopausal women who are given estrogen alone for hormone replacement have approximately a 5-fold increase in the development of endometrial cancer (Gambrell, et al). With the addition of cyclic progesterone, this increased incidence of endometrial cancer has not been noted. Thus, with unopposed estrogen, whether endogenous or exogenous, there is an increased risk of endometrial cancer.

The presenting symptom in patients with endometrial cancer is usually abnormal uterine bleeding. Post-menopausal bleeding is associated with malignancy approximately 20% of the time. Any post-menopausal bleeding should prompt endometrial sampling. In patients prior to menopause with

**‘With unopposed estrogen, whether endogenous or exogenous, there is an increased risk of endometrial cancer. With the addition of cyclic progesterone, however, this increased incidence has not been noted.’**

The presenting symptom in patients with endometrial cancer is usually abnormal uterine bleeding. Post-menopausal bleeding is associated with malignancy approximately 20% of the time. Any post-menopausal bleeding should prompt endometrial sampling. In patients prior to menopause with prolonged irregular menstrual bleeding, especially obese patients, endometrial sampling should be considered. Often, adequate sampling can be performed as an office procedure. However, if it cannot, either because of patient anatomy or intolerance, a fractional dilation and curettage should be performed. A pap smear is not adequate for evaluation of the endometrium. If a pap smear detects atypical endometrial cells,

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even in a patient without irregular bleeding, endometrial sampling should be considered. Hysteroscopy can be of help in diagnosing endometrial neoplasia, especially if clinical picture or biopsy results are confusing.

## Staging

FIGO staging of endometrial cancer is as follows:

Stage I — Carcinoma confined to corpus

1a — Uterine cavity 8 cm. or less

1b — Uterine cavity greater than 8 cm.

Stage II — Carcinoma involves cervix

Stage III — Carcinoma outside the uterus, but limited to the true pelvis

Stage IV — Carcinoma involving the bladder or rectum or outside the true pelvis

The most significant prognostic factors include stage, grade, histologic type, depth of myometrial invasion, and the presence of lymph node metastasis. In patients with Stage I, grade 1 disease with superficial myometrial invasion, metastases are rare, and 5-year survival rates are greater than 95% with surgery alone. In Stage I disease with grade 3 tumor or deep myometrial invasion, 5-year survival rates are approximately 60%. In Stage IV disease, 5-year survival rates are around 10%.

## ‘Clinical staging in endometrial cancer has been notoriously unreliable.’

Equally important is a detailed and specific pathologic interpretation. Stage I disease patients with an endometrioid adenocarcinoma have an approximately 85% 5-year survival, while in those with clear cell carcinoma, leiomyosarcoma or mullerian sarcomas, have 5-year survival rates that are less than 50%. There is another histologic type called a papillary serous adenocarcinoma which behaves more like an ovarian malignancy and is associated with a poor prognosis.

## Treatment

The primary treatment of uterine malignancies has been a combination of radiotherapy and surgery. The initial clinical staging and grade are used to determine the treatment plan. Clinical staging in endometrial cancer has been notoriously unreliable. Pre-operative pelvic radiotherapy and a cesium implant may alter the pathology to the point where accurate identification of poor prognostic factors is difficult.

The trend in recent years has been toward initial surgery to accurately determine the extent of the disease and the presence of

poor prognostic factors. Patients with Stage I grade 1 or 2 disease and superficial myometrial invasion have 5-year survival rates greater than 90% with surgery alone and thus can be spared the morbidity and expense associated with extensive radiotherapy.

Patients with Stage II disease, positive pelvic nodes, grade 3 lesions, deep myometrial invasion, or aggressive histologic type can be selected for postoperative radiotherapy.

Radiotherapy is very effective in preventing disease recurrence in the pelvis, but many patients with poor prognostic factors will recur outside the pelvis and ultimately die of their disease. The value of adjuvant chemotherapy or hormone therapy in these high risk patients is not established.

The use of chemotherapy with either adriamycin or cisplatin in treatment of recurrent disease has been disappointing. Many of the well-differentiated tumors contain hormone receptors. Patients with recurrent disease, including distant metastasis, have had long-time response to progestational agents, especially those with grade 1 tumors.

Our standard treatment for patients with Stage I, grade 1 or 2 disease is to proceed with initial surgery consisting of an exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo oophorectomy, and cytologic washings. The uterus is

sent for frozen section. If there is evidence of middle or deep myometrial invasion or a higher high grade lesion, then a sampling of pelvic and para-aortic lymph nodes is carried out. In patients with obvious Stage II disease or grade 3 lesions, we recommend pre-operative cesium implant followed by an abdominal hysterectomy, oophorectomy, and lymph node sampling.

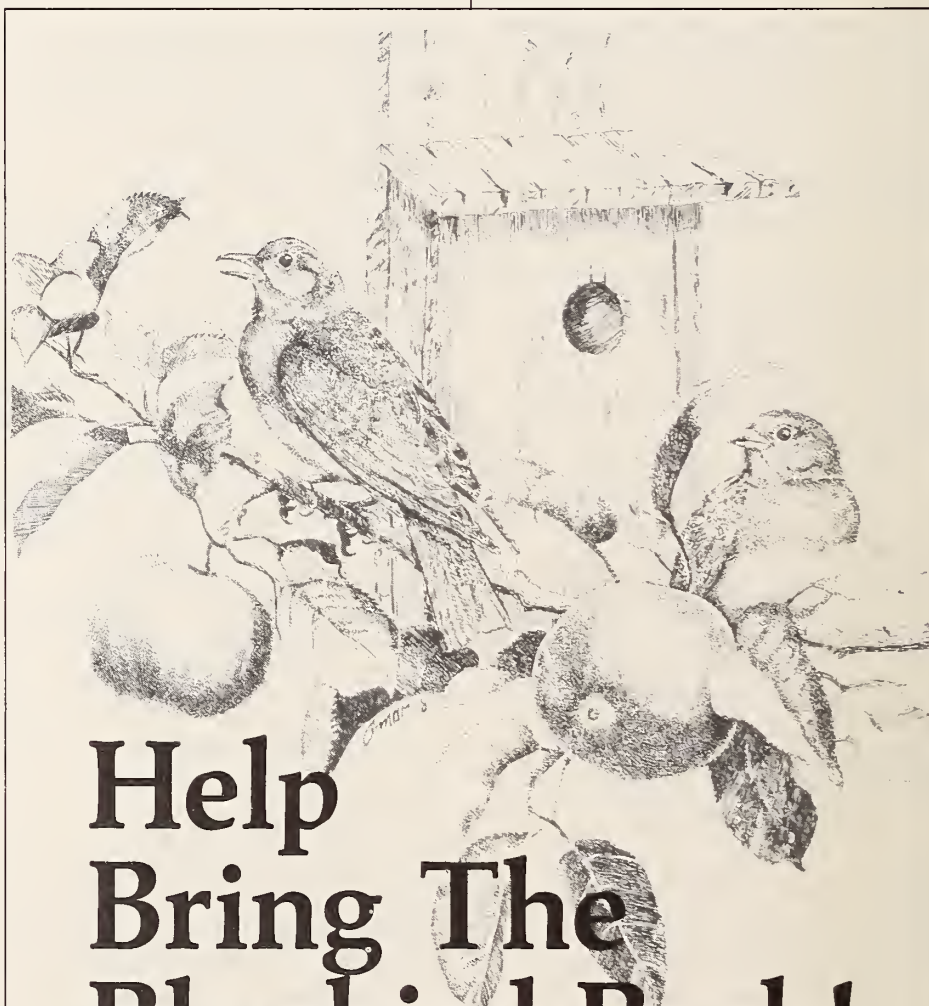
There is a subset of patients whose treatment may be approached differently. The obese premenopausal patients tend to have Stage I disease which is well differentiated and superficially invasive. Their cure rates are greater than 95%. They also have tumors with hormone receptors which tend to respond to progestins. If they desire to retain childbearing capabilities, then a 3-month trial of progestational agents can be considered. After 3 months, a D & C is performed if malignancy persists, then surgery would be advised. If there is no evidence of malignancy, then we could maintain the patient on the progestin until she decides to conceive. In this group of patients, hormone therapy can adequately treat the malignancy approximately 70% of the time.

#### Conclusion

Fortunately, many patients present with early stage disease and are cured from their cancer, however, women are still dying from endometrial cancer. There are several ways in which we can reduce the number of women dying from this disease. First, we must better educate the physicians and patients regarding early symptoms. Next, we need to

develop an effective screening test for endometrial cancer. These can help us detect more disease at an early stage. Prognostic factors must continue to be evaluated, so that we can provide effective

therapy without over-treating. Finally, more work needs to be done concerning adjuvant treatment for high-risk disease and effective methods for treating recurrence.



## Help Bring The Bluebird Back!

Georgia began losing bluebirds in the 1950s because of the combined effects of pesticides and land-use changes that took away nesting cavities in older trees and wooden fenceposts. Now that pesticides such as DDT have been banned in the U.S., bluebirds are making a comeback in Georgia. Because house sparrows and starlings often rob bluebirds of the few nests that do exist, the Georgia Department of Natural Resources is encouraging Georgians to GIVE WILDLIFE A CHANCE by putting out a bluebird nest box this year. Easy-to-assemble kits may be purchased from any State Park for \$7.50 plus tax. Or, request free nest box plans and instructions by writing DNR at 205 Butler St. S.E., Suite 1258, Atlanta, GA 30334.

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## Georgia's Child Abuse Reporting Statute Survives Initial Constitutional Attack

Robert N. Berg

**S**INCE 1965, Georgia health care practitioners and certain other professionals have been obligated by statute to report suspected incidents of child abuse or neglect. Only recently, however, Georgia law enforcement authorities have begun to enforce these statutory obligations, through the initiation of criminal proceedings against alleged violators. This, in turn, has raised questions concerning the constitutionality of the statutory scheme.

In this month's Legal Page, we provide an overview of the current Georgia statutory requirements concerning the reporting of suspected child abuse or neglect. We also describe a recent Georgia Supreme Court case, dealing with the constitutionality of the Georgia statute.

### Overview of Georgia's Child Abuse Reporting Statute

Under Section 19-7-5 of the Georgia Code (the "Statute"), physicians and limited licensed practitioners (such as dentists and podiatrists), as well as certain non-physician professionals (such as social workers, teachers, child care personnel, and law enforcement personnel), having "reasonable

cause to believe" a child under the age of 18 has had physical injuries inflicted upon him or her by a parent or caretaker by other than accidental means, has been neglected or exploited by a parent or caretaker, or has been sexually assaulted or sexually exploited, are required to report such occurrence to the appropriate child welfare agency providing protective services (or, in the absence of such an agency, to an appropriate police authority or a district attorney). In certain institutional cases, such as where a physician learns of the suspected child abuse as a result of serving on the staff of a hospital, the physician is required to notify the person in charge of the hospital or that person's designated delegate, and the duty to report rests with that person.<sup>1</sup>

**Under the Statute, an oral report must be made as soon as possible, by telephone or otherwise, and must be followed by a written report, if requested.**

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**Georgia law enforcement authorities have recently begun to enforce child abuse reporting statutory obligations through the initiation of criminal proceedings against alleged violators.**

by a written report, if requested. The report must contain the names and addresses of the child and his parent or caretaker, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator.<sup>2</sup> In addition, the reporting person may take photographs of the child, without first obtaining the permission of the child's parent or guardian, in order to support his or her suspicion of child abuse; any photographs taken, however, must, if reasonably possible, be taken in a manner so as to not reveal the identity of the child.<sup>3</sup>

Any person participating in the making of a report or causing a report to be made under the Statute will be immune from any liability, either civil or criminal, as long as the person acted in good faith.<sup>4</sup> This immunity also extends to persons participating in judicial or other proceedings resulting from the making of a report. Alternatively, any person required by the Statute to report a suspected case of child abuse who knowingly and willfully fails to do so may be found guilty of a misdemeanor and punished accordingly (up to \$1,000 in fines or up to one year's imprisonment, or both).<sup>5</sup>

#### Who is Obligated to Report?

Application of the Statute oftentimes is difficult in practice; it is drafted broadly in an effort "to provide for the protection of children whose health and

welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection."<sup>6</sup> The potential overbreadth of the Statute may be seen, for example, in the Statute's designation of the individuals required to report instances of suspected child abuse: "Any physician . . . , licensed osteopathic physician, intern, resident, all other hospital and medical personnel, dentists, psychologists, podiatrists, nursing personnel, social work personnel, school teachers and school administrators, school guidance counselors, child-care personnel, day-care personnel, child-counseling personnel, child service organization personnel, or law enforcement personnel."<sup>7</sup>

**R**ecently, in the case of *Gladson v. State*,<sup>8</sup> the Georgia Supreme Court was required to analyze the applicability of the Statute to two persons — one, a licensed psychologist, and the other, a "psychological associate" who, technically, was not a licensed psychologist. Specifically, Ms. Gladson was a "psychological associate" (counselor) at the firm of Affiliated Counseling & Psychological Services (a professional corporation of psychologists). She had a doctoral degree in human development from an accredited university, but had not yet obtained a Georgia license to practice psychology. During the course of her counseling, Ms. Gladson was advised by the mother of two children, ages 10 and 12, that their stepfather had abused them sexually. Ms.

Gladson advised her supervisor, Dr. Powell, a licensed psychologist. Dr. Powell, in turn, apparently advised another licensed psychologist who was the head of the firm, but the alleged child abuse was not reported to an appropriate child welfare agency.<sup>9</sup>

Both Ms. Gladson and Dr. Powell were charged with the misdemeanor of failing to report child abuse under the Statute. The defendants moved to dismiss the charges brought against them under the Statute, raising several constitutional challenges to the Statute. In particular, the defendants argued that the Statute was unconstitutionally vague, both in its description of the persons obligated to report suspected child abuse and in the statutory description of the information required to be reported. Additionally, the defendants argued that application of the Statute would impinge upon the right of privacy inherent in the psychologist/patient relationship. Finally, they argued that the Statute violated each defendant's rights under the 5th Amendment, by requiring a person to provide incriminating evidence to law enforcement authorities.

The Supreme Court chose not to deal with these constitutional arguments, as they related to Ms. Gladson. Rather, the Court found that, because Ms. Gladson was not a licensed psychologist, she could not be held criminally liable for the failure to report the alleged child abuse. In other words, the Court took a narrow view of the coverage of the Statute, literally applying the term



**“Any person participating in the making of a report or causing a report to be made under the Statute will be immune from any liability, either civil or criminal, as long as the person acted in good faith.”**

“psychologist” to mean “licensed psychologist,” despite the intent of the drafters of the Statute that it be “liberally construed so as to carry out the purposes thereof.”<sup>10</sup>

As to Dr. Powell, however, the Court found that he was a licensed psychologist — a term defined by statute<sup>11</sup> and therefore not lacking the requisite clarity to satisfy the Federal and Georgia constitutions — and that, as a result, Dr. Powell could be held criminally liable for failure to report suspected child abuse, under appropriate circumstances. The Court did note that the Statute “as presently drawn, invites serious constitutional inquiry as to its adequacy in defining classes of persons who are required to make reports of child abuse.”<sup>12</sup> While the Court would necessarily have to deal with this problem, in some future case, however, it determined that the Statute was quite clear in its application to Dr. Powell.

#### Conclusion

In light of the Court’s acknowledgement of the serious constitutional issues raised by the

Statute, it must be expected that future cases will again challenge the constitutionality of the Statute. At least for the present, however, the Statute has passed constitutional muster, and may be enforced in appropriate cases, wherein suspected child abuse or child neglect are not reported to the child welfare agency or policy authority.

#### Notes

1. O.C.G.A. §19-7-5(b).
2. O.C.G.A. §19-7-5(a).
3. *Id.*
4. O.C.G.A. §19-7-5(d).
5. O.C.G.A. §19-7-5(e).
6. O.C.G.A. §19-7-5(a).
7. O.C.G.A. §19-7-5(b).
8. \_\_\_\_\_ Ga. \_\_\_\_\_, 376 S.E.2d 362 (February 17, 1989).
9. *Id.*, 376 S.E.2d at 364.
10. O.C.G.A. §19-7-5(a).
11. O.C.G.A. §43-39-7.
12. *Gladson v. State*, *supra*, 376 S.E.2d at 364 (Emphasis supplied).

#### QUOTES

*When once a decision is reached and execution is the order of the day, dismiss absolutely all responsibility and care about the outcome.*

WILLIAM JAMES

*Money is as money does. If it doesn’t, it isn’t.*

EDWARD SMITH

*There’s lots of people in this world who spend so much time watching over their health that they haven’t time to enjoy it.*

JOSH BILLINGS

*Mountebanks, empirics, quack-salvers, mineralists, wizards,*

*alchemists, cast-apothecaries, old wives and barbers are all suppositors to the right worshipful doctor.*

JOHN FORD

*Women love men for their defects; if men have enough of them women will forgive them everything, even their gigantic intellects.*

OSCAR WILDE

*It saves a lot of trouble, instead of having to earn money and save it, you just go and borrow it.*

WINSTON CHURCHILL

*Man is not the creature of circumstances, circumstances are the creatures of man.*

BENJAMIN DISRAELI

*Do men like to fish or do they just like to get away from it all?*

WILLIAM FEATHER

*I am a great friend to public amusements, for they keep people from vice.*

SAMUEL JOHNSON

*Money is power, freedom, a cushion, the root of all evil, the sum of blessings.*

CARL SANDBURG

*Men always want to be a woman’s first love — women like to be a man’s last romance.*

OSCAR WILDE

*Natural forces within us are the true healers of disease.*

HIPPOCRATES

*As the French say, there are three sexes — men, women, and clergymen.*

Ascribed to SYDNEY SMITH in *A Memoir of the Rev. Sydney Smith* by his daughter, Lady Holland, 1855





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## *Prenatal Diagnosis of Congenital Heart Disease Using Fetal Echocardiography*

*Kim Wetherington, M.D.*

### **Introduction**

**U**NLESS CONGENITAL HEART disease actually can be prevented, e.g., removal of environmental teratogens, the only way to improve mortality is by early recognition and specialized care.<sup>1</sup> Fetal echocardiography as a diagnostic modality has evolved since the early 1970s into a definitive method for diagnosis of congenital heart disease. The following is a review of fetal echocardiography, its indications, its use in evaluating specific cardiac anomalies, and its effect on medical management.

### **Background**

The first method of fetal heart evaluation with sonography was M-mode echocardiography, which was difficult at best, with a moving fetus. With the advent of more sophisticated imaging, this modality was easier to use, and with high resolution equipment, prenatal diagnosis of congenital heart disease was made feasible. It has been shown that by using sequential analysis in real-time cross-sectional imaging, one can systematically and consistently identify normal and, hopefully, abnormal cardiac anatomy. This sequential analysis can be accomplished by first identifying the heart, then the four chambers, then the atrioventricular connections, and finally the ventriculoarterial connections.<sup>2-4</sup>

Although the fetal heart is developed by the 8th week of gestation, it is generally accepted that fetal echocardiography cannot be performed with reasonable accuracy until about the 18th week of gestation. The 18th week is a desirable time to perform echocardiography, because at this point in gestation, the cardiac structures are large enough to be imaged, but the fetus is still considered previable, making termination of pregnancy a realistic option for those parents who choose to do so. Fetal echocardiography can be performed easily until the 32nd week of gestation, when the method becomes more difficult secondary to a relatively decreased amniotic fluid volume and fetal immobility.<sup>5</sup>

Real-time cross-sectional echocardiography is the mainstay in evaluation of fetal cardiac structure. However, other imaging modes are equally important in specific situations. M-mode echocardiography is essential in evaluation of fetal arrhythmias at the time of diagnosis, and also during interventional therapy. This

mode also is quite useful for measurements of cardiac chambers and vessels.<sup>2</sup> Doppler echocardiography is important in assessing hemodynamics and can be helpful in delineating complex cardiac malformations. One group has outlined four situations in which Doppler study may be best used: (1) when sonographic resolution is poor, e.g., with unfavorable fetal lie, Doppler may serve to guide the orientation of the transducer; (2) when accurate assessment of intracardiac hemodynamics is needed for diagnosis, e.g., Doppler may identify a ventricular septal defect shunt not identifiable by cross-sectional imaging; (3) when measurement of cardiac output is needed for diagnosis, e.g., Doppler can identify ventricular output in fetal hydrops with high output cardiac failure; and (4) when cross-sectional echocardiography cannot adequately delineate complicated cardiac malformations.<sup>6</sup> Thus, several different modes of sonographic imaging may be used to evaluate the fetal heart, and their use can be tailored to the individual patient.

Although fetal echocardiography has been demonstrated to be quite accurate in prenatal diagnosis, it is not without certain limitations. Factors which limit the use of fetal echocardiography include maternal obesity, unfavorable fetal

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*This paper was prepared at the request of the Georgia Affiliate of the American Heart Association. Those wishing to contribute papers to this department should send them to the Department Editor, Dr. Wesley Covitz, at the above address.*

lie, oligohydramnios, polyhydramnios, and gestational age < 18 weeks or > 32 weeks.<sup>7,8</sup> Several series have been done which indicate that more severe cardiac malformations are more easily detected than simpler defects, e.g., an isolated, small ventricular septal defect or mild valvular disease.<sup>5,9,10</sup> Even with these disadvantages, fetal echocardiography will prove to be an important aid in diagnosing cardiac anomalies prenatally.

### Indications

Some idealists might advocate generalized screening of all pregnancies with fetal echocardiography. However, this broad-ranged screening is neither financially feasible nor time efficient. It becomes necessary, then, to establish a fairly standard list of indications which place a fetus at a relatively increased risk for developing heart disease. These indications are proposed throughout the literature and will be reviewed here.<sup>3,5,7,10,11</sup>

Risk factors for the development of congenital heart disease can be categorized according to whether they pertain to fetal problems, maternal factors, or family history (Table 1). Problems identified in the fetus which indicate the need for fetal echocardiography include symmetric intrauterine growth retardation. A significant number of these fetuses have chromosomal abnormalities, which dramatically increase the risk of congenital heart disease. In these instances, the incidence of heart disease has been reported as high as 99%.<sup>7</sup> Fetal arrhythmias are another indication

**TABLE 1 — Indications for Fetal Echocardiography**

FETAL
—IUGR
—Arrhythmia
—Bradycardia
—Extracardiac Malformation
—Non-immune Hydrops
—Chromosomal Abnormalities
MATERNAL
—Exposure to Teratogens
ETOH
Amphetamines
Anticonvulsants
Lithium
Viruses
—Rh Sensitization
—Diabetes Mellitus
—Preeclampsia
—Collagen Vascular Disease
FAMILIAL
—Congenital Heart Disease
(in previous offspring or parent)

for prenatal echocardiography; these include tachyarrhythmia, bradycardia, and ectopic beats. Since they are often associated with cardiac defects, extracardiac malformations and identified chromosomal abnormalities are also risk factors which necessitate fetal echocardiograms.<sup>12</sup> Finally, any fetus with non-immune hydrops should undergo echocardiography, since many times a cardiac cause for the hydrops is found.<sup>4</sup>

Maternal risk factors which indicate the need for further fetal cardiac evaluation include exposure to specific teratogens. These teratogens include alcohol, amphetamines, anticonvulsants, lithium (associated with Ebstein's Anomaly), and certain viruses. Maternal Rh sensitization and preeclampsia are indications for fetal echocardiography, since both cases may be associated with fetal hydrops. Maternal diabetes

mellitus is a well known entity associated with congenital cardiac malformations and asymmetric septal hypertrophy as is maternal collagen vascular disease (associated with congenital heart block); therefore, fetal cardiac evaluation should be performed in all of these patients.

A family history of congenital heart disease, either in a parent or a sibling, is another indication for fetal echocardiography. The need for careful and deliberate screening of all mothers is apparent; with identification of those at risk, prenatal diagnosis then may be made, perhaps improving outcome of those pregnancies.

### Specific Cardiac Abnormalities

Fetal arrhythmias can be associated with structural heart disease, but even without structural defects they can cause serious, life-threatening problems. Arrhythmias are best evaluated by combined cross-sectional and M-mode echocardiography. Ectopic beats are one form of arrhythmia which must be followed carefully, as they can be associated with spontaneous occurrence of a sustained arrhythmia. Tachyarrhythmias also must be monitored closely because they are often the cause of in utero congestive heart failure. Fetal echocardiography can be invaluable in following tachyarrhythmias which are being treated with transplacental pharmacologic cardioversion. Finally, bradycardia has been reported to have a 50% incidence of congenital heart disease, and any fetus with bradycardia should be evaluated carefully with



echocardiography.<sup>13</sup>

Non-immune hydrops fetalis carries a grave prognosis and should be evaluated carefully to determine etiology and possible modes of intervention. Many cases of non-immune hydrops are secondary to a cardiac defect; in one study, 10 of 13 fetuses with non-immune hydrops had a cardiac abnormality as a cause.<sup>14</sup> Fetal echocardiography is useful in determining these cardiac abnormalities and is mandated in all fetuses with non-immune hydrops.

Many aneuploidy syndromes are associated with congenital heart disease.<sup>12</sup> The incidence of aneuploidy in fetuses with echocardiographically diagnosed congenital heart disease has been reported from 25-32%.<sup>10, 12</sup> The chromosome abnormalities identified most commonly were Trisomies 13, 18, 21 and Turner's Syndrome. Thus, it is possible to identify the cardiac manifestations of genetic syndromes prior to amniocentesis and chromosomal analysis. This finding indicates that chromosomal analysis of all fetuses with known congenital heart disease is probably an efficient and relatively productive screen for genetic diseases.

### Effect on Medical Management

Prenatal diagnosis of congenital heart disease influences prenatal care and improves neonatal care.<sup>12</sup> The assessment of fetal cardiac anatomy helps in genetic counselling, treatment of cardiac arrhythmias, and planning delivery and postnatal management.<sup>3</sup> With advanced knowledge of congenital heart disease, timely intervention can

be planned, e.g. Prostaglandin E<sub>1</sub> can be instituted immediately after birth in previously diagnosed ductal-dependent lesions.<sup>7</sup> Transplacental cardioversion with pharmacologic agents can be attempted and is often successful in prenatally diagnosed supraventricular tachycardia.<sup>13</sup> Other intervention which can be planned when heart disease is diagnosed prenatally is atrial septostomy in transposition of the great arteries; this can be performed early on, prior to the onset of significant deterioration of the infant.<sup>15</sup> Finally, if congenital heart disease is diagnosed early in gestation, prior to viability of the fetus, termination of the pregnancy may be offered to the parents, especially in cases of multiple fetal anomalies, e.g., Trisomy 18. Even if the parents decide against termination of the pregnancy, the early knowledge of congenital heart disease is important in counselling, and the decision to avoid heroic measures can be made in a controlled, relatively calm situation. Obviously, prenatal and postnatal management are greatly influenced by diagnosis of heart disease with fetal echocardiography, often with improvement in outcome of affected fetuses.

### Conclusion

Advances in echocardiographic technology have made prenatal diagnosis of congenital heart disease feasible in those fetuses identified at increased risk. Fetal echocardiography also is useful in monitoring therapeutic interventions and in identifying fetuses with possible genetic

syndromes. The knowledge gained from fetal echocardiography is invaluable as an aid to obstetrical management, parental counselling, and perinatal care of the affected infant.

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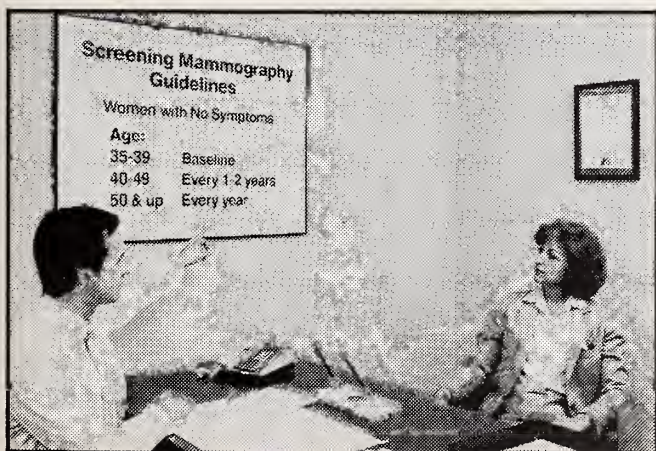
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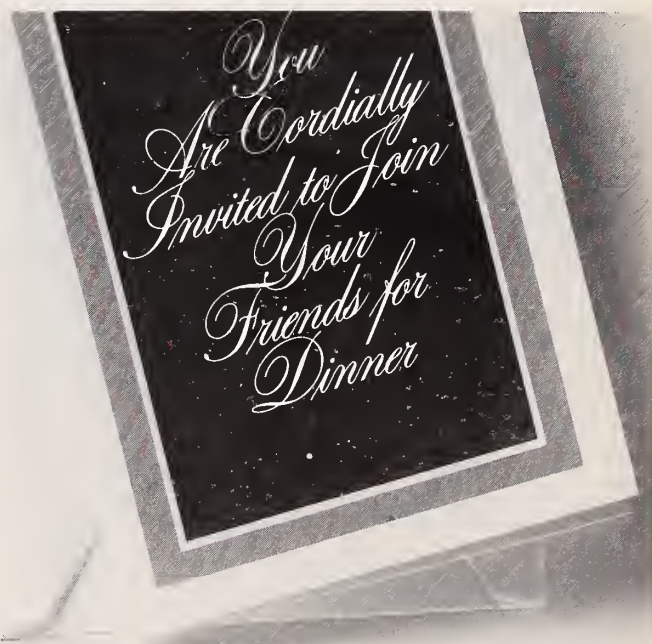
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# VASOTEC®

## (ENALAPRIL MALEATE | MSD)

**Contraindications:** VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions:** *General:* **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Osmotic reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium ( $> 5.7$  mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients:

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

#### Drug Interactions:

**Hypotension in Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucoside, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of  $^{14}$ C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**Hypertension:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**Heart Failure:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostatic hypertrophy.

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

#### Clinical Laboratory Test Findings:

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration:** **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance  $> 30$  mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance  $\leq 30$  mL/min (serum creatinine  $\geq 3$  mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium  $< 130$  mEq/L) or with serum creatinine  $> 1.6$  mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg. For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. JEV 518R (815)

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JULY 1989

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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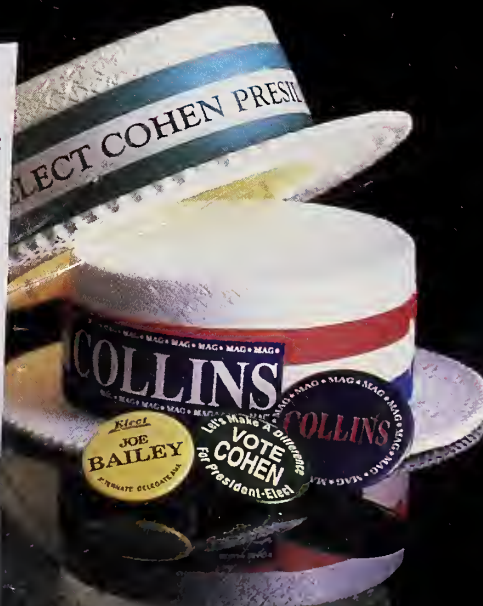
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## 1989 PROCEEDINGS

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

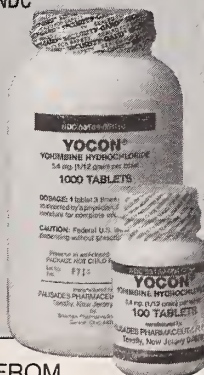
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

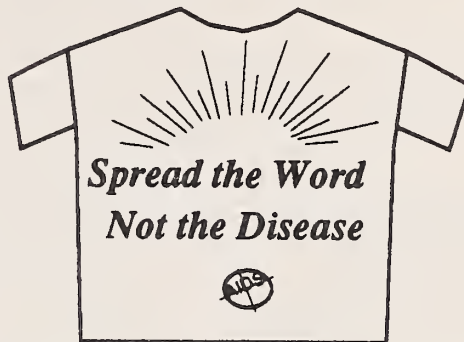
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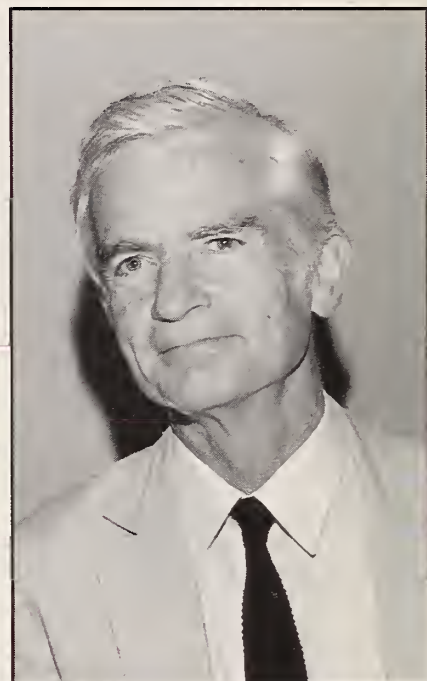
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## *The Third Act*

*"Life is a three-act play with a badly written third act"*

**I**MPROVING LIFE'S THIRD ACT will be the focus of our efforts during the next year. The over-65 population in Georgia will double in the next 10 years. This year, President Bush, through Graham-Rudman, has recommended a \$5 billion cutback in medical funding. With our increasingly complex and costly armamentarium of tests and procedures, we must place the emphasis on quality of life. Figures show that 50 cents of the medical dollar is expended in the patient's final month of life.

This year, the Georgia



*Joe L. Nettles, M.D.*

Legislature made three separate efforts to mandate Medicare assignment, in one case tying it to medical licensure. The Aetna Part B Medicare coverage snafu has the AARP worried that Georgia physicians will abandon the elderly.

Through our Senior Citizen's Advocacy Committee and our Public Relations Committee we are making efforts to see that the elderly, like all other citizens, are properly cared for.

We can re-write Life's script and provide a third act that has quality and meaning. After all, we will ultimately be the beneficiaries of our efforts.

A handwritten signature in dark ink, reading "Joe L. Nettles". The signature is fluid and cursive, with the first name "Joe" being more prominent.



## NEW MEMBERS

Barnhill, James E., Cardiology —  
Gwinnett-Forsyth — (Active)  
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Lawrenceville 30245

Barratt, Peter J., Obstetric/  
Gynecology — MAA — (Active)  
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Atlanta 30327

Bashuk, Robert G., Neurology —  
Cobb — (Active) 3910 Austell  
Rd., Ste. 204, Austell 30001

Bassey, Ephraim N., Internal  
Medicine/Nephrology — MAA  
— (Active N2) 777 Cleveland  
Ave., Ste. 305, Atlanta 30342

Berndt, George A., Colorectal  
Surgery — MAA — (Active N2)  
5667 Peachtree Dunwoody Rd.,  
Ste. 330, Atlanta 30342

Bruner, Phillip M., Obstetrics/  
Gynecology — Bibb —  
(Resident) 777 Hemlock St.,  
Macon 31201

Chitluri, Jaisree R.,  
Ophthalmology — Clayton-  
Fayette — (Active) Bldg. B, Ste.  
5, 181 Upper Riverdale Rd.,  
Riverdale 30274

Coussens, Patricia D., Obstetrics/  
Gynecology Ocmulgee (Active)  
Pulaski Professional Bldg. B,  
Hawkinsville 31036

Daugherty, J. Thomas, Family  
Practice — Floyd-Polk-  
Chattooga — (Resident) Floyd  
County Hospital, Turner McCall  
Blvd., Rome 30161

Davis, Donald M., Anesthesiology  
— MAA — (Active) 1000  
Johnson Ferry Rd., Atlanta  
30042

Desai, Rajiv D., Obstetrics/  
Gynecology — Walton —  
(Active N1) 330 Alcova St.,  
Monroe 30655

Dixit, Bhushit S., Psychiatry —  
Muscokee — (Active) 1472  
Millingham Rd., Columbus  
31904

Fenlon, Patrick B., Internal  
Medicine — Thomas Area —  
(Active) 114 Mimosa Dr.,  
Thomasville 31792

Flax, Fredric B., Pediatrics —  
MAA — (Active) 45 West  
Crossville, Ste. 501, Roswell  
20075

Fraga, Rick, Cardiothoracic  
Surgery — Clayton-Fayette —  
(Active N2) 506 Westbridge Dr.,  
Fairburn 30213

Frederick, Hal M., Diagnostic  
Radiology — Clayton-Fayette —  
(Active) 33 S.W. Upper  
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Riverdale 30274

Gottlieb, Alan J., Internal  
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N.E., Ste. 301, Atlanta 30309

Gowitt, Gerald T., Forensic  
Pathology — MAA — (Active  
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Atlanta 30303

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Savannah 31401

Harless, Dean M., Anesthesiology  
— Gwinnett-Forsyth — (Active)  
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Hearth-Holmes, Michelene P.,  
Internal Medicine — MAA —  
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Decatur 30030

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Dermatopathology — Cobb —  
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Georgia Medical — (Active N2)  
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Savannah 31419

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Oncology — Whitfield-Murray  
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Dr., Dalton 30720

Murray William, General Practice  
— MAA — (Active) 1282 Avalon  
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Olsen, Chris L., Pathology —  
Muscogee — (N2) P.O. Box  
4176, Columbus 31995

Poland, Donald E.,  
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360, Lawrenceville 30245

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DeKalb — (Active) 755  
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Peachbelt — (Active) 131-B  
Carl Vinson Pkwy., Warner  
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MAA — (Active) 1928 Peachtree  
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— Bibb — (Resident) Medical  
Center of Central Georgia, P.O.  
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Sports Medicine — Cobb —  
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Point 30344

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Woodfin, Blane A., Orthopaedics  
— MAA — (Active N1) 77  
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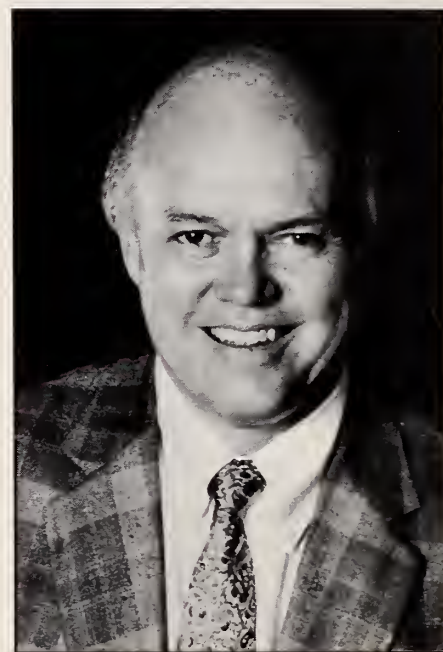
Yuk, Antonio C., Neurosurgery —  
MAA — (Active N2) 340 Blvd.,  
Ste. 412, Atlanta 30312

## PERSONALS

*Medical Association of Atlanta*

**John H. Hartley, Jr., M.D.**,  
was re-elected historian of The  
American Society for Aesthetic  
Plastic Surgery, Inc., at its annual  
meeting last April

Emory cardiologist **J. William  
Hurst, M.D.**, received the  
Theodore E. Cummings Prize for  
Excellence in Cardiovascular  
Diseases in ceremonies at Cedars-  
Sinai Medical Center in Los  
Angeles, California, last April. The



Dr. Hartley

award, considered one of the  
most important awards in  
medicine and the single most  
prestigious in the field of heart  
disease, was presented to Dr.  
Hurst by former President Ronald  
Reagan and Mrs. Theodore E.  
Cummings, widow of the man for  
whom the prize is named. In  
presenting the award, President  
Reagan noted it was for a  
"lifetime contribution to the field  
of cardiovascular medicine." Dr.  
Michael DeBakey, the first  
recipient of the Cummings Prize,  
paid special recognition to Dr.  
Hurst's work as author of the  
book, *The Heart*, the most widely  
used medical text in cardiology.

**James O. Mason, M.D.**, has  
been confirmed unanimously by  
the U.S. Senate to become  
Assistant Secretary of Health in  
the U.S. Department of Health and  
Human Services (HHS). He will  
direct seven federal health  
agenices with a total budget of  
\$13.8 billion.

Dr. Mason has been director of  
the Centers for Disease Control  
(CDC) in Atlanta since 1989.



## DEATHS

**Thomas Andrew "Bill" Cochran, Sr., M.D.**, a family physician in Ringgold, died last February at the age of 66.

A former medical officer at TVA's Sequoya Nuclear Plant and the Volunteer Army Ammunition Plant, Dr. Cochran had once been Chief of Staff at Tri County Hospital, now Hutcheson Medical Center, in Fort Oglethorpe. He was a graduate of the Medical College of Georgia and had served as a captain in the Medical Department of the U.S. Army in World War II. Dr. Cochran was a member of several professional associations and community organizations.

He is survived by his wife, one daughter, two sons, and six grandchildren.

**W. Dean Warren, M.D.**, Decatur, an internationally known pioneer in liver surgery and chairman of the Department of Surgery at Emory University's School of Medicine since 1971, died of cancer on May 10. He was 64.

He had been ill for 4 years but continued teaching and performing operations, including the liver surgery bearing his name, until last December.

Under Dr. Warren's leadership, the surgery department at Emory University School of Medicine attracted leading surgeons in various specialties. Dr. Warren formed a liver surgical team that enabled Emory to become one of

the few hospitals in the world offering all major therapies for chronic liver diseases, including transplantation. His research in liver surgery and the special surgical procedure that bears his name — the Warren shunt — are recognized internationally.

Dr. Warren received a B.A. degree from Dartmouth College and completed the 2-year program at Dartmouth medical college. In 1950, he received his M.D. degree from Johns Hopkins University School of Medicine.

Dr. Warren interned at Johns Hopkins Hospital and completed residencies at the University of Michigan Hospital in Ann Arbor and Barnes Hospital in St. Louis. He joined the University of Virginia faculty and began



*Dr. Warren*

research on surgery of the pancreas and for portal hypertension.

In 1960, he won a Markle scholarship and did research at the Institute for Experimental Surgery and the Rishospitalet of the University of Copenhagen.

Dr. Warren was a professor and the surgery department chairman at the University of Miami School of Medicine before being named the Joseph Brown Whitehead professor and chairman of Emory's surgery department in July 1971.

Dr. Maurice J. Jurkiewicz, director of Emory's Division of Plastic and Reconstructive Surgery, cited Dr. Warren's commitment to postgraduate studies and faculty development.

Dr. Garland D. Perdue, director of the Emory Clinic and medical director of the university hospital, said Dr. Warren inspired his colleagues.

"His life and his work will endure in the minds, hearts, and hands of his students and colleagues," Dr. Perdue said.

Dr. Warren, who would have been 65 years of age in October, had planned to step down as surgery department chairman at the end of the school year.

Dr. Warren was president of the American College of Surgeons in 1986-87. He was a former president of American College of Surgical Association, Southern Surgical Association, Society for Surgery of the Alimentary Tract, the Whipple Society, and Society of University Chairmen.

## JULY

31-Aug. 4 — *Atlanta: A Comprehensive Board Review in Internal Medicine*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## AUGUST

3-5 — *Hilton Head, SC: Current Financial Strategies*. Category 1 credit. Contact Div. of Cont. Ed., MCG, August 30912. PH 404/721-3967.

10-13 — *Hilton Head, SC: Georgia Psychiatric Physicians Association*. Category 1 credit. Contact Jim Moffett, MAG, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

14-18 — *Amelia Island, FL: Summer Imaging and Interventional Techniques VII*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## SEPTEMBER

11-12 — *Atlanta: Interventional Radiology for Technicians & Nurses*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-15 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Atlanta: Clinical Psychiatry*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-19 — *Atlanta: Third Annual Menopause Conference*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of

Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-23 — *Hilton Head, SC: Frontiers in Nutrition*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-23 — *Atlanta: Lung Cancer Conference*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta: Medical Retina Workshop*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-26 — *Atlanta: Quantitative Thallium Myocardial Tomography*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-28 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXII*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-29 — *Atlanta: Congress of Neurological Surgeons*. Contact CNS, 1840 North Soto St., Room 100B, Los Angeles, CA 90022. PH: 213/224-5435.

25-29 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## OCTOBER

4-6 — *Atlanta: Biliary Lithotripsy and Adjunct Procedures*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: GA Chapter, American Academy of Pediatrics*. Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., Atlanta 30346. PH: 404/237-3922.

9-11 — *Savannah: Neonatology — The Sick Newborn*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-13 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-14 — *Atlanta: Renal Disease Conference*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

13-14 — *St. Simon's Island: Nephrology Update 1989*. Sponsored by The National Kidney Foundation of Georgia. Category 1 credit. Contact NKGK, 1639 Tullie Circle, Suite 108, Atlanta 30329. PH 4004/248-1315 or 800/633-2339.

15-20 — *Atlanta: American College of Surgeons*. Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH: 312/664-4050.

15-20 — *Atlanta: American Society of Colon & Rectal Surgeons*. Contact ASCRS, 800 E. Northeast Hwy. #1080, Palatine, IL 60067. PH: 312/359-9184.

23-24 — *Atlanta: Quantitative Thallium Myocardial Tomography*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



## Why Study History?

Judson C. Ward, Jr., Ph.D.

**G**ENERATIONS OF STUDENTS have asked that question. Many of them find history to be dull — too many dates, lists of rulers, battles, and trivial facts. Many more find it impractical — it won't help them get a job or earn a dollar.

With these objections, why do we continue to subject the young to a study of the past? Why do we force them to study an uninteresting subject, especially when so many adults agree with them that it has no practical value?

The traditional rationale for including history in the course of study is that a knowledge of history is an essential part of education for effective citizenship. In a democratic society all students are potential voters, and in order to play that role they must have some knowledge of government and politics to be able to analyze current questions. In a broader sense, the study of history is designed to help understand how we came to be what we are; to comprehend the interactions of various segments of society; to understand political processes; and in the international sphere, to grasp the causes of war and the limitations of peace.

Even if we concede that the study of history has a practical side in the preparation for citizenship, are there no other useful benefits to be gained from

such study? Is it not possible that there are additional useful results from taking a backward look, even for members of the "here and now" generation?

**T**here are two admirable qualities in well rounded human beings which I suggest may possibly be nurtured by the study of history. They are (1) perspective and (2) appreciation or gratitude.

Perspective is a valuable aspect of the intellectual equipment of the well educated. The ability to bring perspective to the analysis of any situation makes it possible to see more than the immediate present. Perspective enables one to view both the present and the past — to avoid tunnel vision by seeing the situation in a broader view — in context and in perspective.

Quick judgments, made only on the basis of the immediate present, can result in gross errors. Such judgments may prevent or delay effective solutions; whereas longer study based on insights which are possible from seeing the total picture in historical perspective may result in sounder judgments, which actually save time and effort in the long run.

The study of history should equip a student with an effective method for approaching problems of any nature in any field. It should help develop an attitude

or technique for problem solving — a way of looking at a problem. It should prepare a person to ask, "How did the situation develop? What brought on the problem?" In exploring the background, possible solutions may appear. Certainly some unworkable solutions may have been tried, and having been seen, may be avoided. Such study should also produce a concern to judge the impact of a decision on related areas and prevent blindness to the welfare of neighbors. This requires rising above the specific and immediate in order to see the problem area as a whole.

Few would deny that the qualities which we are describing are valuable, but some might question whether they should or can be taught. They would argue that they are little but common sense and that they will come in time to a person as he or she gains experience and maturity. Might they not be inspired or nurtured, however, by a study which instills the long and the broad view? Not all students can be expected to emerge from their study of history with perspective as a part of their problem solving technique, but surely many of them will have the habit of taking a backward look so ingrained in

*(Continued on p. 483.)*

Dr. Ward is Professor of History Emeritus, Emory University. His address is 929 Vistavia Circle, Decatur, GA 30033.

## On Escaping — Riding the East Wind

*"Ah, Sweet Mystery of life, at last I've found you."*

SOURCE UNKNOWN

*"If a man does not keep pace with his companions, it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away."*

HENRY THOREAU

THERE SEEMS TO BE in each of us, we "humankind," the need, or at least the urge, to on occasion loose the constraints — the shackles, the boredom, tedium or sameness — of our daily lives. For some of us, it need be only an evening out. For others, a long weekend. Still others require a greater distancing from their work, a week or a month. For some I am acquainted with, their work is their play. Or so they say. For each of us, however, there seems to be a need for a change of pace. We call it a vacation. Though present all the year long, that need strikes us most predictably in summertime.

I encountered a medical friend in the hospital while making rounds one morning. The conversation revolved around vacation plans. "You must have lost the Florida lottery." It was quick and casual, hopefully not well thought out, response to his first query. "You must be on the way out of town. Where to now?" he had asked. "Thailand." It came

from me with a grain of trepidation.

Early on I had thought as had he. "A hairbrained scheme," I said when it was first mentioned. "You are out of your mind." The reaction worked until my traveling companion saw the "side trip." "They are going to ride elephants!", she exclaimed. "It's still hairbrained. Hardly a way to do C.M.E." I thought the matter settled and put it aside.

Absolutely marvelous," she said. "I've always dreamed about it. I just can't believe I am really doing this!" Lurching recklessly about in the Howdah, precariously perched atop the massive animal, gazing with frightened rapture into the valley which lay beyond clear vision below us, I thought, "nor can I." It snorted then, exhaled with astonishing vigor, trumpeted I believe they say. As I cowered to receive the shower of pent up respiratory secretions, water and mud, she gazed into my incredulous eyes. "Are you having fun yet?" That same sign was over the bulletin board in the operating room when I left home. "Yes, I think so," wiping the mud from my eyes.

Somewhere along the trail, the travail, I thought of Kipling. Quite proper it seemed at the time. After all, it was he, the English, who had first settled this land. First romanticized it. "You deserve

what you got," I thought. "You come back and ride this elephant." But in his absence I remembered, The Ladies. He wrote about them in a little poem one time.

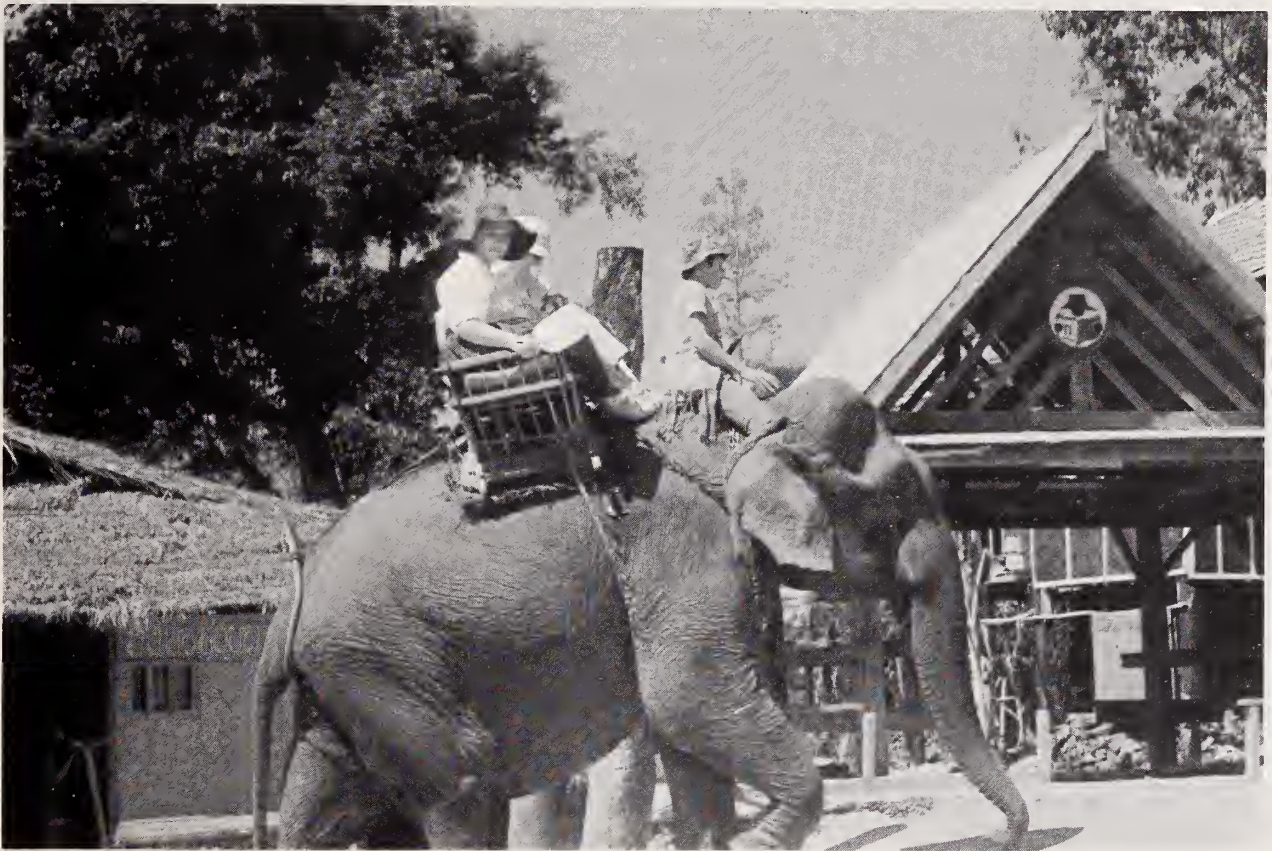
*"I've taken my fun where I've found it;  
I've rogued an' I've ranged in my time;  
I've 'ad my picklin' o' sweethearts,  
An' four o' the lot was prime.  
One was an 'arf-caste widow,  
One was a woman at Prome,  
One was the wife of a jemadar-sais,  
An' one is a girl at 'ome."*

Damn you Rudyard, I thought. "You take your fun where you find it. Let me take mine where I will."

It is a happy time at home now. "That's me on the elephant with the chain around its neck," I proudly proclaim as the next slide glides across the screen. They laugh. "You look so happy. So excited," they say. "Scared," I say.

Surely, I have no doubt about it, we take our fun where we find it. But take it we must, for there is too much grimness in this daily work we do. Enough happiness, joy, and fulfillment, too, of course, but somehow we must on occasion untether our minds, the hidden inner self, from the daily constraints of our work. It may in fact be the only way that we can reach that wellspring of harmony





*The editor and his companion lurching along in the Howdah atop this massive animal as they "Ride the East Wind." (Are they having fun yet?)*

and peace and productivity, the "Bliss" that Joseph Campbell, the Master of Myth, talks about.

He goes on to say that we all have within ourselves the potential for stressless and harmonious living if only we could find it. It seems to be an adventurous search, a search for Self, as he explains the matter. Perhaps we all need to listen to him.

And so it is that we come again

to summer. To the beach and the mountains. To travel in foreign lands. To riding the East Wind and the elephant. Somehow it seems to me that the depressed patient or physician, the psychotic, the simply unhappy or unfulfilled, they all alike fail to find summer. Fail to find it in July and August. Fail also to find it in October and March. Fail to look with intent for their bliss. Fail to ride the East Wind. Fail to ride

the elephant. Fail to "take their fun where they found it." We must do better. Our happiness, our productivity, our meaningfulness depend upon it. We simply must:

Look for our Bliss  
Feel the East Wind  
Ride the Elephant

Happy, Happy Summer!!

CRU

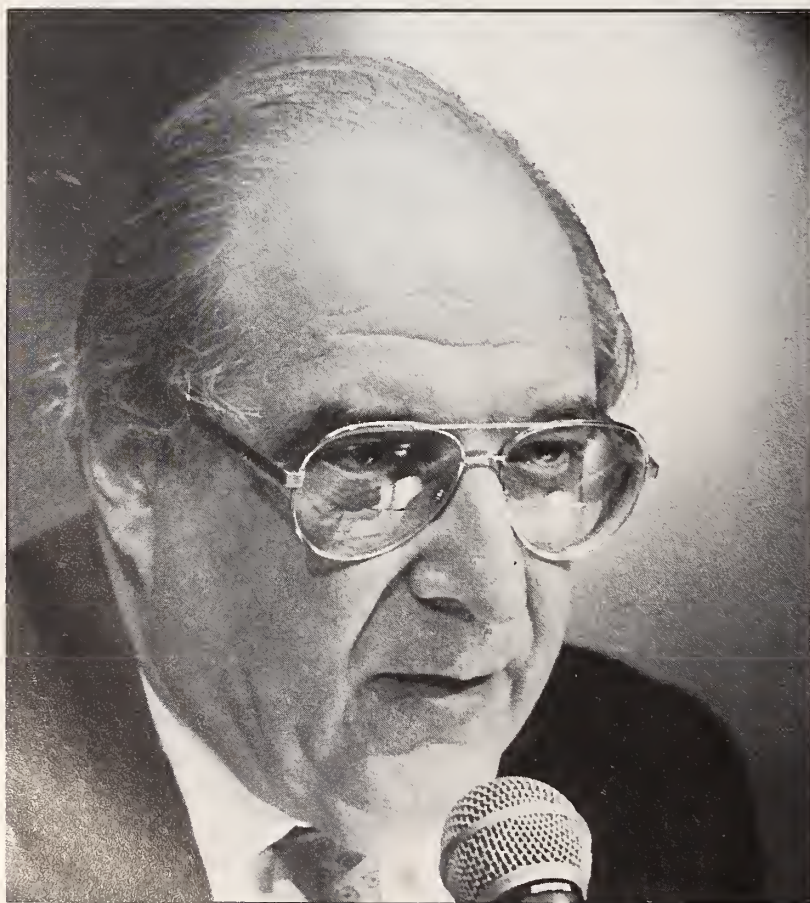


# *First General Session*

## *Summary of the Proceedings*

# *135th House of Delegates*

*May 4-6, 1989*



*Speaker of the House James A. Kaufmann, M.D., of Atlanta, calls the 135th House of Delegates to order.*

### **Call to Order**

**T**HE FIRST GENERAL SESSION of the 135th Annual Session of the Medical Association of Georgia was called to order by the President, Joseph P. Bailey, Jr., M.D., of Augusta, at 7:00 p.m., Thursday, May 4, 1989, at the Hyatt Ravinia in Atlanta.

Reverend Hubert Flanagan of the Trinity on the Hill, United Methodist Church in Augusta, delivered the invocation. Jana Hill (Mrs. Robert S.) sang the National Anthem, accompanied by Glenda Bates (Mrs. John) on the piano. Dr. Bailey then led the group in the Pledge of Allegiance.

### **Welcome**

Dr. Bailey welcomed all those attending the 1989 MAG Annual Session and introduced Dr. William Whitaker, President of the DeKalb Medical Society, the host for this



year's Annual Session. On behalf of the members of the DeKalb Medical Society, Dr. Whitaker welcomed the audience to Atlanta.

### Memorial Service

Dr. Bailey requested that the audience stand as he read the names of those physician members who had died in the last year: John W. Acree, Teofredo C. Aranas, Evert A. Bancker, Frank Lee Bivings, Franklin G. Blaydes, Gunar N. Bohan, Charles P. Brooks, L. E. Brown, Perry L. Cohn, Frank N. Copeland, William Coppage, Clyde L. Crawford, Arthur J. Crumbley, Jr., John Dodd, Jr., Van B. Elliott, Leo A. Erbele, Paul E. Fitzpatrick, Darius Flinchum, Ben J. Giles, H. Lee Hall, S. L. Hancock, Robert M. Howard, William F. Huger, Jr., William P. Hust, James D. Kelly, George M. Lane, L. Richard Lanier, Alexander G. Little, Jr., Ben K. Looper, C. G. Magnan, J. O. Martin, Joseph Massee, McCleod Patterson, Irene A. Phrydas, Marta Pruce, Lewis McDonald, Joseph Mendeloff, W. C. Mitchell, Thomas H. Moseley, Youssef Mouna, John T. Persall, J. Harry Rogers, Kirk Shepard, Zachariah S. Sikes, Morris Taranto, Nancy Thornton, W. E. Upchurch, E. T. Upson, E. Van Buren, Thomas Vansant, James P. Watson, Samuel A. Wilkins, Jr., and George A. Williams, Jr.

### Fifty-Year Members

Fifty-year members are those physicians who have been practicing medicine for 50 years or more. Those achieving that status this year are Morgan Charles Adair, Lane Harris Allen, Thomas Edward Bailey, Tully T. Blalock, John Brantley Crawford, Robert Edwin Dallas, Albert M. Deal, Thomas J. Floyd, Jr., Leon Lapidés, Milton Mazo, James D. Manget, Jr., Robert Ford Mabon, James Wright Stapleton, Bruce Swain, Walter Gainey Thwaite, Abraham S. Velkoff and C. Mark Whitehead.



*The Session was attended by 240 delegates and 18 alternate delegates, representing 44 county medical societies.*

### Life Members

Life members are those physicians who have supported organized medicine for at least 25 years and are at least 70 years of age.

Life Membership in MAG was awarded to the following physicians: Pierce Allgood, William R. Birdsong, H. William Bondurant, Edmund A. Brannen, Robert L. Brown, Clarence C. Butler, Elliott A. Cobb, Joe S. Cruise, Ernest G. Edwards, Jr., William G. Erickson, E. C. Evans, Harold A. Ferris, Thomas R. Freeman, William H. Hill, Bernard C. Holland, Lee Howard, Jr., Charles M. Huguley, Milton J. Krainin, Philip I. Krugman, John

R. Lewis, Jr., Marian F. Olansky, Irene Phrydas, William E. Pound, F. C. Powell, J. S. Reynolds, Sterling H. Richardson, P. C. Shea, Jr., John E. Steinhaus, Richard L. Stone, Ben R. Thebaut, Corbett H. Thigpen, Nathaniel A. Thorton, John B. Varner, Julian Q. Watters, Caroline J. Williams, Lionel M. Yoe.

### Certificates of Appreciation

Certificates of Appreciation are presented to those of our members and others who have been active in Association affairs and through their talents and hard work have made





*Delegates gathered in the Hyatt Ravinia Hotel in Atlanta to establish policy and direct MAG in the upcoming year.*

special contributions to medicine and the medical association of Georgia.

The following individuals were awarded certificates: Joseph P. Bailey, Jr., M.D., for his term of President; Richard W. Cohen, M.D., for his term as 1988-89 First Vice President; Bob G. Lanier, M.D. for his term as Second Vice President, 1988-89; Jan Collins, President, Auxiliary to the MAG (A-MAG), 1988-89; S. William Clark, Jr., M.D., as President and Chairman of the Board, Georgia Health Network; William W. Moore, Jr., M.D., for his years as a dedicated member of the MAG-AMA Delegation; George W. Shannon, M.D., for his term as Chairman, Continuing Medical Education Committee, 1986-89; William C. Pfister, M.D., for his term as Chairman, Computers in Medicine Committee, 1987-89; Donald W. Campbell, M.D., for his term as Chairman, Young Physicians Section, 1988-89; Gregory A. Foster, M.D. for his term as Chairman, Resident Physicians Section, 1987-89; William C. Waters, III, M.D., for his term as Chairman, Medical Schools Committee, 1984-89; J. Rhodes Haverty, M.D., for his term as Chairman, AD Hoc Committee on Medical Care for the Disadvantaged, 1986-88; William A. Hopkins, M.D., for his years as a member of the Committee on Prison Health Care, 1981-89; Ingrid Brunt, for her term as AMA-ERF Chairman, A-MAG, 1987-89; Barbara Tippins, "It's Up to Youth" Forum, A-MAG, 1988-89; Connie Menendez, "It's Up to Youth" forum A-MAG, 1988-89; Cheryl Dennis, for her term as Legislative Chairman, A-MAG, 1988-89; Peter Knox, a friend of medicine; Boone Knox, a friend of medicine; Alice O'Riley Kaufmann, R.N., for her work with the Doctor of the Day Program at the Georgia Legislature; George F. Green, M.D., a state representative and family physician for his untiring support of medicine and the MAG; Georgia Senator Paul Coverdale, an advocate of quality med-



ical legislation; Nancy McCord, A-MAG Membership Chairman; and Joseph Wilber, M.D, an advocate of quality medical care with the Georgia Department of Human Resources.

The following Georgia state senators also received Certificates of Appreciation as advocates of quality medical legislation: Mark Taylor, Nathan Dean, Hugh Regan, Bill Fincher, and Jim Tysinger. Other Georgia state representatives similarly honored were: Tom Wilder, Bill Lee, Wesley Dunn, Billy Randall, Terry Coleman, and Jack Kingston.

## Introduction of the President-Elect

Dr. Bailey introduced Dr. Joe Nettles, of Savannah, 1988-89 President-Elect of MAG, who delivered a few brief remarks to the House of Delegates.

## Report of the Auxiliary

"Getting our act together and taking it on the road" was the theme of Jan Collins' (Mrs. William C.) year as President of the Auxiliary to the MAG. Mrs. Collins recounted the many activities of the Auxiliary this past year, especially delighting the audience with a video about the "It's Up to Youth" Forum held at the University of Georgia last March. [Ed. note: See the May MAG *Journal* for more highlights of the Auxiliary activities this past year.]

## AMA-ERF Checks

Each year, the American Medical Association-Education Research Foundation distributes funds to the medical schools received from contributions — mainly from the medical family — that are collected in large part by the Auxiliary to the American Medical Association and by its various organizations. Mrs. Ingrid Brundt of the A-MAG assisted Dr. Bailey in the presentation of money raised for our four medical schools: the Medical College of Georgia, Emory University School

of Medicine, Morehouse School of Medicine, and Mercer University School of Medicine.

## Awards

### Hardman Cup

The first of these awards to be presented this evening is the Medical Association of Georgia's most prestigious. It is the Hardman Cup. This award is presented for "the achievement of anyone who in the judgement of the Association has solved any outstanding problems in public health or made any discovery in medicine or surgery or such contribution to the science of medicine."

This award is *not* given annually, but only on such occasions that a candidate merits this special honor. This award was first given in 1949 to Dr. John Elliott of Savannah. In the 39 years since it was first presented, it has been given only 20 times. It was last presented last year to Dr. William Foege, of Atlanta.

This year's recipient is **Dr. Harold P. Katner**, an infectious disease specialist from Macon. Dr. Katner received his medical degree in 1980 from the Louisiana State University Medical School. Following his postgraduate training and a fellowship in infectious disease at the Ochsner Foundation Hospital and Clinic in New Orleans in 1985, Dr. Katner moved to Macon where he opened his practice for infectious disease. He is a member of the faculty at Mercer University School of Medicine and participates in chemical research.

Since 1984, Dr. Katner has published over 20 articles in medical journals throughout the United States. He has given of his own time to over 100 community programs to church members, public schools, civic organizations, and health care personnel on the prevention of HIV infections, in addition to over 90 lectures, grand rounds, and programs to medical societies or groups.

Dr. Katner's current research project includes "Survey of Cultural Changes in the Gay Community in Relation to the Onset of the AIDS Epidemic," "Endoscopic Cleaning Procedures Relative to Potential Risks of Nosocomial Spread of HIVL III/LAV" and the "Efficacy of Graphic AIDS Education in Middle and High School Students."

He has been a leader in disseminating accurate AIDS information to the Bibb County community. He has provided a most valuable and needed service to Bibb County in regards to this dreaded and controversial disease. Most importantly, he treats compassionately and without hesitation patients who desperately need his help because there is no other avenue of hope for them.

### Civic Endeavor Award

The second award is unique among all of the awards given by the MAG. It is the Civic Endeavor Award, and its purpose is to honor those physicians who motivations find their essential expression in doing good deeds for the public through participation in civic affairs.

The recipient of this award this year is **Dr. Herbert R. Karp**, a neurologist from Atlanta. Dr. Karp exemplifies the best traditions of our profession in his practice of medicine, and at the same time has made significant contributions to the civic life in his community and the state.

Dr. Karp is presently the Director of the Division of the Geriatric Medicine at Emory University School of Medicine and Director of Medical Services at the Wesley Woods Center. Yet he has found the time, somehow, to contribute in a significant manner to his community.

Dr. Karp has involved himself heavily over the years in many aspect of the community. He has supported the arts, serving on the Board of Directors of the Atlanta Symphony; supported civic works, as



evidenced by his active work with United Way; and contributed to his religious community, by serving as President of the Atlanta Chapter of the Zionist Organization of America, as President of the Ahavath Achim Synagogue, and actively participating in the Atlanta Jewish Federation.

Dr. Karp has been especially interested in the issues surrounding the aged, serving as a member on the Committee on Aging of the Atlanta Jewish Federation for the last 3 years in addition to his works with Wesley Woods. It should be noted that he was a recipient of Emory University's Thomas Jefferson Award, the university's top award recognizing significant service through personal activities, influence, and leadership.

#### *Distinguished Service Award*

This award is presented for distinguished and meritorious service which reflects credit and honor on the association. Over the past 29 years, this award has been presented only 22 times.

Our winner this year is one of MAG's most favorite members, **Dr. William W. Moore, Jr.** In presenting this award to Dr. Moore, MAG is recognizing his contributions and service to organized medicine for over 40 years.

Never satisfied to follow, Dr. Moore has always been a leader in medicine. He has served with distinction as President of the Medical Association of Atlanta, President of the Georgia Neurosurgical Society, President of the Southern Medical Association, and President of the Medical Association of Georgia. He is currently a delegate to the House of Delegates of the American Medical Association, a position that he has just announced that he will retire from at the end of this year.

#### *Family Physician of the Year*

The selection of the recipient is made by the Board of Directors of

the Georgia Academy of Family Physicians, and the presentation is made here at our annual meeting.

**Dr. Charles A. Lanford** of Macon, is this year's recipient of this prestigious award, which was presented to him by Dr. Richard Wherry, of Dahlonega, President of the Georgia Academy of Family Physicians.

#### *A.H. Robins Physician Award for Community Service*

This award, established in 1961, under the urging of A. H. Robins' Chairman, E. Claiborne Robins, provides recognition to physicians for the many and varied services above and beyond the call of duty which they render to their respective communities.

A. H. Robins makes the award available in the belief that members of the health team should use all appropriate ethical means of improving and enlarging the stature of the physician, as a professional and a participant in community life. This year's recipient is **Dr. Harry R. Foster, Jr.**, a pediatric/pediatric allergist from Lithonia.

Dr. Foster, a native of Commerce, carried on a family tradition of medical service when he became a physician. He served as Chief of the Department of Pediatrics at Georgia Baptist Medical Center, and Chairman of the Medical Staff at Henrietta Egleston Hospital for Children and currently is Chief of Pediatrics at DeKalb Medical Center.

He is an instructor in pediatric cardiology at Emory. He has served as staff medical director of the Children's Medical Services, Atlanta Cardiac Program, since 1965. He has volunteered each Tuesday afternoon to see cardiac patients from all over Georgia, and four times a year he staffs the Children's Medical Cardiac Clinic in Columbus.

However, it is his service to his community that makes Dr. Foster

so unique. He has been an elder, youth advisor, and Sunday School Teacher at Lithonia Presbyterian Church. As team physician for the Lithonia Athletic program since 1964, he has provided over 6500 pre-participation athletic physicals at no charge. He served on the DeKalb County schools systems' committee on discipline and was awarded life membership in the Lithonia school PTA for his work with the organization.

In January, the DeKalb Medical Society presented to Dr. Foster the Julis McCrudy Citizenship Award in recognition of outstanding community service.

#### **Announcements**

Before concluding the First General Session, Dr. Bailey directed several items of interest to the audience's attention:

1. The House of Delegates will convene immediately at the conclusion of this General Session. Dr. Louis W. Sullivan, United States Secretary of Health and Human Services, will be our honored guest speaker at that time. The House is scheduled to recess at approximately 10 p.m. Reference Committees will begin promptly at 9:00 a.m., Friday morning.

2. GaMPAC will sponsor a breakfast for us in the morning at 7:30 with guest speaker Congressman Charles Hatcher.

3. MAG Mutual will sponsor an open forum luncheon tomorrow at noon.

4. Congressman Ben Jones will address the House on Saturday morning.

5. At 7:00 p.m. on Saturday is the MAG and Auxiliary President's Reception.

This concluded the business of the First General Session. The First Session of the House of Delegates started approximately 5 minutes later.



**I**t is the light of the laser. And the miracle it is performing in the medical world. At DeKalb Medical Center, this remarkable tool has taken the form of Laser Lithotripsy, an alternative to percutaneous or transurethral lithotripsy procedures to fragment stones in the middle and upper ureter. The major advantage to the procedure is the reduced risk of damage to the ureteral wall. The

procedure itself delivers a pulsating laser beam through a microscopic, flexible fiber directly to the stone. It can be viewed through a miniaturized scope. Often, it can be performed on an outpatient basis. Laser lithotripsy may be utilized on most stones in any part of the urinary tract.

Or it may be used to complement our Extra-Corporeal Shock Wave

Lithotripsy (ESWL), which uses externally generated shock waves on the stone to fragment it. Shock wave lithotripsy, significantly more costly than laser, is best limited to stones occurring in the kidney or upper third of the urinary tract.

With the emphasis on outpatient procedures, DeKalb Medical Center offers CO<sub>2</sub> Laser Surgery, which seals lymphatics and nerve endings as it cuts, reducing post-operative edema, pain, bleeding and surgical time. At DeKalb Medical Center, CO<sub>2</sub> procedures are used mainly for GYN, urology and general surgery. On a more general basis, the procedure is used for breast resections, tumor excisions, debridement, endometriosis, pelvic adhesions and genital wart virus. A new process using the CO<sub>2</sub> Laser is operative laparoscopy, which allows surgeons to perform complex intrapelvic procedures through a scope, without requiring a large incision.

The YAG Laser is used by urologists for bladder tumors; by gynecologists for endometrial ablation; and by gastroenterologists for obstructive lesions, polyps or strictures of the GI tract.

All these state-of-the-art laser applications are another reason you and your patients can feel confident DeKalb Medical Center will continue to provide the most effective technologies. Because we believe that's the brightest approach to patient care.

# **DEKALB MEDICAL CENTER HAS SEEN THE LIGHT.**



**DeKalb Medical Center**

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# First Session House of Delegates

## Thursday, May 4

**T**HE FIRST SESSION of the MAG House of Delegates was called to order by the Speaker of the House, James A. Kaufmann, M.D., at 8:30 p.m., Thursday, May 4, 1989, in the Ballroom of the Hyatt Ravinia Hotel, in Atlanta. Jack A. Raines, M.D., of Columbus, served as Vice Speaker of the House.

The Speaker then enjoined the delegates with the following remarks:

"The constitution directs that the 'House of Delegates is the legislative body of the Association and it shall transact all business of the Association.' The decisions you make over the next 3 days will become the policy of the Association, and they will determine the course of action that our Association will follow for the coming year. I urge you to appreciate the full weight of this responsibility. As members of this legislative body, each of you represents not only the physician members of your respective county medical societies, but also in fact, physicians in all parts of the state."

Dr. Bailey was then called upon to introduce the honored guest speaker for the evening, Dr. Louis W. Sullivan, former President of Morehouse School of Medicine in Atlanta and the newly appointed

U.S. Secretary of Health and Human Services. [Ed. note: Dr. Sullivan's remarks to the House appear elsewhere in this issue of the *Journal*.]

### Report of Credentials Committee

The Speaker called for a report from the Credentials Committee which was given by Dr. Bob Lanier of Atlanta. Dr. Lanier reported that 240 delegates representing 44 component county medical societies were in attendance and accordingly, announced that a quorum of the House of Delegates was present.

### Delegate Attendance

Donald C. Abele, William C. Acton, William E. Adams, Vicente R. Ajoy, Bruce S. Allen, David C. Allen, Joseph M. Almand, Jr., Thomas J. Anderson, Jr., Robert H. Anderson, Jr., Catherine S. Andrews, John S. Antalis, Manolo B. Apanay, Harold Asher, James L. Askew, Phil C. Astin, Jr., Harold Asher, James E. Averett, Jr., Ivan A. Backerman, Joseph P. Bailey, Jr., C. Robert Baisden, Phillip N. Bannister, William A. Barber, William E. Barfield, Sr., James C. Barlow, J. Dan Bateman, John G. Bates, James F. Beatlie, Jr., William Biggers, H. Duane Blair, Allan C. Bleich, David C. Bosshardt, Gary Botstein, Rupert H.



Bramblett, Clinton E. Branch, Jr., Spencer S. Brewer, Larry Brightwell, A. Patrick Brooks, William P. Brooks, Algie Brown, Rodney M. Browne, Gwynne T. Brunt, Jr., William L. Buhrow, Dan Burge, Carson B. Burstiner, Billy D. Burk, Robert A. Burns, William B. Burns, Jr., E. Napier Burson, Jr., Leon H. Bush, Joseph G. Bussey, Jr., Rodrigo Cabezas, Louis G. Cacchioli, Donald H. Campbell, Frank E. Carlton, Albert A. Carr, Curtis Carter, Robert Glenn Carter, Thomas S. Claiborne, Jr., Alvin Clair, Elizabeth Clark, S. William Clark, Jr., Spurgeon William Clark, III, Teresa E. Clark, Michael J. Cohen, Richard W. Cohen, Chappell A. Collins, Jr., William C. Collins, William S. Colvin, Terrence J. Cook, George W. Cox, David E. Dalrymple, John W. Darden, Robert L. Davies, Alfred L. Davis, Jr., R. Carter Davis, Jr., Ervin D. DeLoach, Sammie Dixon, William L. Dobes, Jr., F. W. Dowda, Julian Duttera, Jr., J. W. Estes, J. Patrick Evans, Louis H. Felder, Daniel M. Feldman, Sumner Fishbein, Gilbert J. Foster, Jr., Harry Foster, David J. Frolich, Stefan H. Fromm, T. Kirkland Garner, T. Schley Gatewood, Jr., John A. Goldman, Kenneth L. Goldman, James S. Goodlet, O. L. Gray, Joe L. Griffeth, Joseph W. Griffin, Jr.

Thomas L. Haltom, Carl V. Hancock, Jr., Thomas A. Hanson, Ralph L. Haynes, Buford G. Harbin, William R. Hardcastle, J. Harold Harrison, J. Rhodes Haverty, Patricia Haynes, William M. Headley, John P. Heard, William C. Heard, Irving D. Hellenga, Peter Henderson, E. V. Herrin, John Hinkle, Tom Hope, Warren B. Horn, John A. Hudson, Charles Humphries, Dirk E. Huttenbach, Mark C. Hutto, Anthony F. Is-ele, Eugene H. Jackson, Joseph M. Jackson, Kenneth Jago, Milton I. Johnson, Jr., George R. Jones, Saunders Jones, Jr., William B. Jones, James A. Kaufmann, Ellis B. Keener, J. Weldon Kelley, Kerry King, P. Rao Kondur, Charles A. Lanford, Bob G. Lanier, J. Moultrie Lee, Walter M. Ligon, Werner Linz, Charles Gary Lodge, J. Robert Logan, William D. Logan, Jr., Gary R. Loveless, Louis O. J. Manganiello,

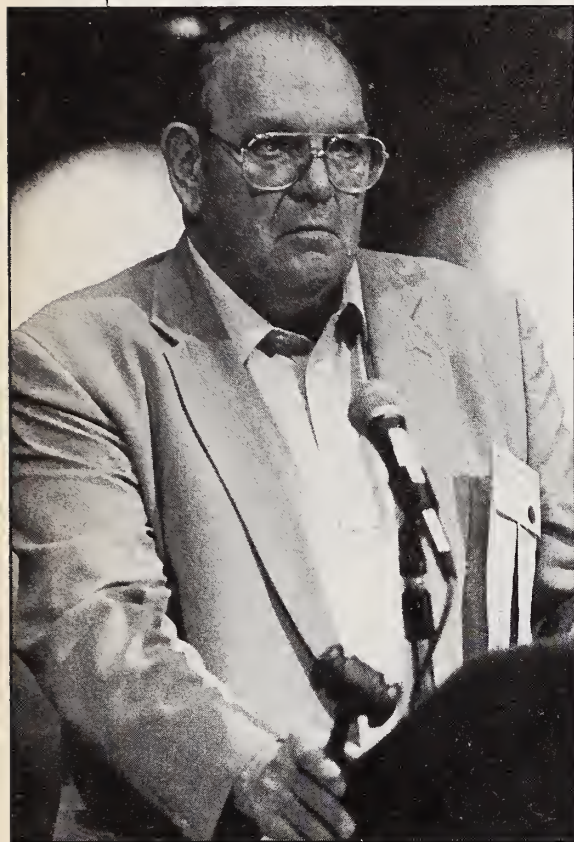
Joy A. Maxey, William E. May, Alva Louie Mayes, Jr., Harry C. McDonald, Charles W. McDowell, Jr., Virgle W. McEver, Jr., Virgle W. McEver, III, Peter Meehan, Jack F. Menendez, Margaret Mermin, Arthur J. Merrill, Jr., Cecil L. Miller, E. M. Molnar, W. W. Moore, Jr., Martin J. Moran, Rene A. Morell, Hugo S. Moreno, Joseph V. Morrison, Jr., Gerald B. Muller, Ellis H. Nelson, Joe L. Nettles, Bruce C. Newsom, John S. Newton, Jeffrey T. Nugent, James L. O'Quinn, Carol H. Oster, Dolford F. Payne, Garland D. Perdue, Jr., George Petrides, William

C. Pfister, Dent W. Purcell, Allan Plummer, Thomas E. Price, Carol Pryor, Keith A. Quarterman, Corinne F. Quinn, J. L. Rabb, Jack A. Raines, Walter J. Ratchford, John D. Richmond, Stanley P. Riepe, Wells Riley, John E. Roberts, Jr., Michael H. Roberts, Harrison L. Rogers, Jr., Jim Lee Rogers, E. A. Roper, Ronald P. Roper, Ronald Rosen, Lawrence Ruf, F. Stuart Sanders, Gerald E. Sanders, Donald Schaffner, J. K. Schellack, Nathan Segall, George L. Smith, Rodney L. Smith, Tyson D. Smith, Jr., David Sowell, Charles C. Stamey, Cassius M. Stanley, III, Dan



*Delegates William C. Collins, T. William Dowda, Richard A. Cohen, Louis Felder, Tom Anderson, Luther Thomas, Ed Molnar, and Robert Wells are among those pictured here.*





Jack A. Raines, M.D., a psychiatrist from Columbus, served again this year as Vice Speaker.

B. Stephens, Richard A. Stappenbeck, Joe C. Stubbs, O. Wytch Stubbs, Jr., James H. Sullivan, David D. Tanner, Earle M. Taylor, H. Wayne Templeton, Luther M. Thomas, Jr., Hugh S. Thompson, Jr., William C. Tippins, Jr., James H. Tison, Charles E. Todd, Jr., Jerry C. Tootle, Fred A. Trest, Karl Ullman, Charles R. Underwood, William S. Vancise, Roy W. Vandiver, Edward J. Waits, William C. Waters, III, John D. Watson, Jr., Alexander H. S. Weaver, Robert E. Wells, William N. Wessinger, G. Marc Wetherington, J. Q. Whitaker, William G. Whitaker, III, Paul A. Whitlock, Jr., William R. Wills, Jr., Joseph S. Wilson, Sr., Thorne S. Winter, III, William A. Wolff, J. Trevor Woodhams, C. Allen Woods, Jr., Asa G. Yancey, John T. Yauger.

## Alternate Delegates

Robert L. Buckley, Harry N. Dorsey, Mark D. Durden, III, David R. Fern, John E. Fowler, Atwood M. Freeman, Jr., J. Harper Gaston, C. E. Johnson, Jr., W. K. Lane, Harold S. Ramos, Samuel L. Strickland.

Vice Speaker Raines introduced the parliamentarian, Mrs. Mary Lou Stephens, noting that the Robert's Rules of Order would be followed.

Members of the Tellers Committee, chaired by Dr. John Schellack were introduced as follows: Dr. William Clark, III, Dr. Dan Stephens, and Dr. Carson (Bucky) Burgstiner.

## Adoption of Minutes

The Proceedings of the 1988 meeting of the MAG House of Delegates as published in the June, 1988, *Journal of the Medical Association of Georgia*, with a subsequent correction regarding Reference Committee C in the August issue, were approved.

## Nominations of Opposed Elections

Speaker Kaufmann announced that only those candidates with opposition will be listed on the ballot for the Saturday, May 6, election.

Speaker Kaufmann called on the House to proceed with nominations for opposed offices:

**President-Elect:** William C. Collins, M.D., Atlanta, was nominated for President-Elect by Hugh S. Thompson, M.D., East Point, and seconded by Alva L. Mayes, Jr., M.D., Macon.

Richard W. Cohen, M.D., Austell, was nominated for President-Elect by Rene A. Morell, M.D., Marietta, and seconded by Jack F. Menendez, M.D., Macon.

**Speaker of the House:** James A. Kaufmann, M.D., Atlanta, was nominated for Speaker of the House by Hugh S. Thompson, M.D., East Point, and seconded by Joe L. Nettles, M.D., Savannah.

F. William Dowda, M.D., Atlanta, was nominated for Speaker of the

House by Harrison L. Rogers, Jr., M.D., Atlanta.

**AMA Delegates:** F. William Dowda, M.D., Atlanta, was nominated to succeed himself by Harrison L. Rogers, Jr., M.D., Atlanta.

Jack F. Menendez, M.D., Macon, was nominated for AMA Delegate by Charles A. Lanford, M.D., Macon, and seconded by Milton I. Johnson, Jr., M.D., Macon.

## Election of Unopposed Candidates

It was agreed at the outset that unopposed candidates would be elected at this Session and the names of the candidates who have opposition would appear on the ballot for election, Saturday, May 6, 1989. Upon nominations duly made and seconded as indicated below, the following slate of unopposed officers were elected by acclamation:

**Vice Speaker, House of Delegates:** Jack A. Raines, M.D., Columbus, was nominated by William H. Hayes, M.D., Columbus, and seconded by Joy A. Maxey, M.D., Atlanta.

**First Vice President:** As Second Vice President, Bob G. Lanier, M.D., Atlanta, automatically becomes First Vice President; therefore, no election is required for this position.

**Second Vice President:** Roy W. Vandiver, M.D., Decatur was nominated for Second Vice President by William G. Whitaker, III, M.D., Decatur, and seconded by James H. Sullivan, M.D. of Columbus.

**AMA Delegate:** Due to the announcement of William W. Moore, Jr., M.D., Atlanta, not to seek reelection as AMA Delegate, Virgle W. McEver, Jr., M.D., Warner Robins, was nominated by Virgle W. McEver, III, Warner Robins, and seconded by William W. Moore, Jr., M.D., Atlanta.

**AMA Delegate:** C. Emory Bohler, M.D., Brooklet, was nominated to succeed himself by Paul Whitlock, M.D., Statesboro, and sec-



ended by Robert Logan, M.D., Savannah.

**AMA Delegate:** Charles D. Hollis, Jr., M.D., Albany, was nominated to succeed himself by Mack Freeman, M.D., Albany, and seconded by J. Rhodes Haverty, M.D., Atlanta.

**Alternate Delegate:** Richard W. Cohen, M.D., Austell, was nominated to succeed himself by Rene A. Morell, M.D., Marietta, and seconded by Joe C. Stubbs, M.D., Valdosta.

**AMA Alternate Delegate:** William D. Logan, Jr., M.D., Atlanta, was nominated to succeed himself by Jeffrey T. Nugent, M.D., Atlanta, and seconded by Spencer S. Brewer, Jr., M.D., Augusta.

**AMA Alternate Delegate:** Joseph P. Bailey, Jr., M.D. Augusta, was nominated by Albert Carr, M.D., Augusta, and seconded by Louis H. Felder, M.D., Atlanta, to fill the position previously held by Virgle W. McEver, Jr., M.D., Warner Robins.

**AMA Alternate Delegate:** Due to the nomination of Jack F. Menendez, M.D., Macon, as AMA Delegate in opposition of the position currently held by F. William Dowda, M.D., Atlanta, Louis H. Felder, M.D., was nominated by Harrison L. Rogers, Jr., M.D., Atlanta, and seconded by Bob G. Lanier, M.D., Atlanta.

**MAG Delegate to AMA Young Physician Section:** Joy A. Maxey, M.D., Atlanta, was nominated by James F. Beattie, Jr., M.D., Fort Oglethorpe, and seconded by Donald H. Campbell, M.D., Marietta.

**MAG Alternate Delegate to AMA Young Physicians Section:** James F. Beattie, Jr., M.D., Fort Oglethorpe, was nominated by Joy A. Maxey, M.D., Atlanta, and seconded by Donald H. Campbell, M.D., Marietta.

**Judicial Council:** Due to the ineligibility for re-election of John M. Martin, M.D. Augusta, Curtis H. Carter, M.D., Augusta, was nominated by Joseph P. Bailey, Jr., M.D., Augusta, for a term to expire in 1992.

**Judicial Council:** By action of the House of Delegates in bestowing upon C. Emory Bohler, M.D., Brooklet a seat on the Medical Associations of Georgia's Executive Committee, Dr. Bohler is now obliged to relinquish his seat as Chairman of the Judicial Council. Because such vacancies are filled by Presidential nomination, Joseph P. Bailey, Jr., M.D., Augusta, nominated John D. Watson, Jr., M.D. Columbus, to serve as Chair of the Judicial Council.

## Directors and Alternate Directors

Speaker Kaufmann announced the result of elections for Directors and Alternate Directors, as conducted by the District Medical Societies and Component County Medical Societies, with Terms to expire 1992:

*Ninth District Medical Society Director*

John Ed Fowler — Clayton

*Ninth District Medical Society Alternate Director*

C. Peter Lampros — Tiger

*Cobb County Medical Society Director*

Dan B. Stephens — Marietta

*Georgia Medical Society Director*

J. Patrick Evans — Savannah

*Georgia Medical Society Alternate Director*

Roland S. Summers — Savannah

*Gwinnett-Forsyth County Medical Society Director*

Rupert Bramblett — Cumming

*Gwinnett-Forsyth County Medical Society Alternate Director*

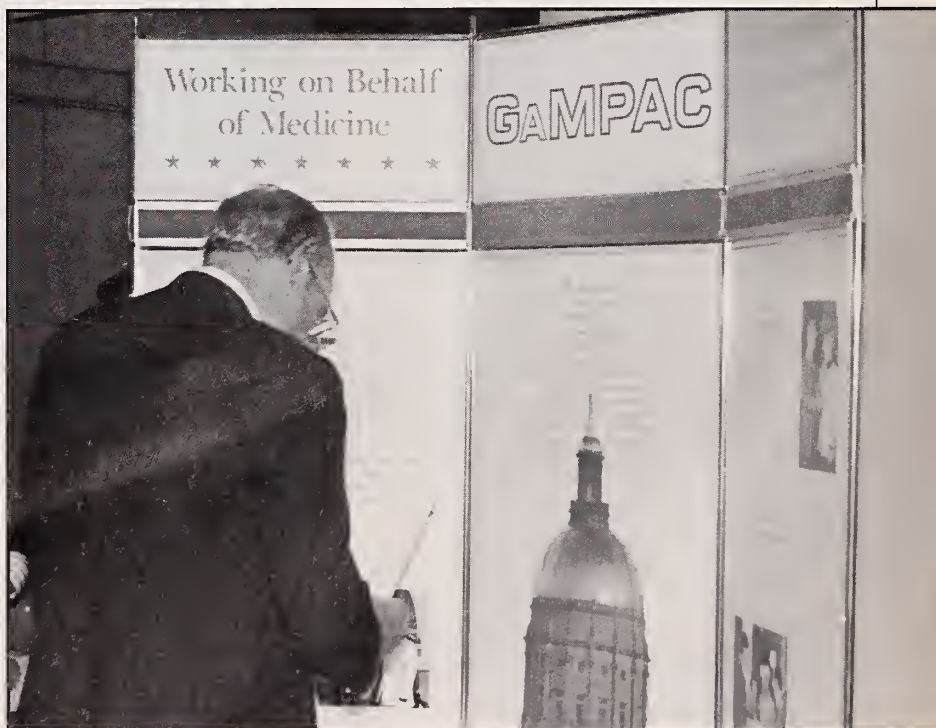
Cecil L. Miller — Buford

*Medical Association of Atlanta Director*

William C. Collins — Atlanta

*Medical Association of Atlanta Alternate Director*

Bob G. Lanier — Atlanta



*GaMPAC works on behalf of the entire medical profession, advancing the goals of the medical profession through political involvement.*



## *Muscogee County Medical Society Director*

E. M. Molnar — Columbus

## *Muscogee County Medical Society Alternate Director*

Ken L. Goldman — Columbus

### **Reports of Officers**

President's Report — Not referred

President-Elect's Report — Referred to Ref. Comm. C.

Immediate Past President's Report — Rec. 1, referred to Ref. Comm. C; Rec. 2, referred to Ref. Comm. B; Rec. 3, referred to Ref. Comm. A.

First Vice President's Report — Referred to Ref. Comm. A.

Chairman of the Board's Report — Not referred.

Secretary's Report — Not referred.

### **Reports of Directors**

The following Directors' reports were not referred to a Reference Committee: First District Medical Society, Second District Medical Society, Third District Medical Society, DeKalb Medical Society, Medical Association of Atlanta, Sixth District Medical Society, Seventh District Medical Society, Eighth District Medical Society, Ninth District Medical Society, Tenth District Medical Society, Bibb County Medical Society, Clayton-Fayette County Medical Society, Cobb County Medical Society, Crawford W. Long Medical Society, Floyd-Polk-Chattooga Medical Society, Dougherty County Medical Society, Georgia Medical Society, Hall County Medical Society, Muscogee County Medical Society, Richmond County Medical Society.

### **Reports of Departments**

*Journal of the Medical Association of Georgia* — Not referred.

### **Reports of Sections**

The following section reports were not referred: Medical Student

Section, Young Physician Section, Resident Physician Section.

### **Special Reports**

AMA Delegation — Not referred.

Georgia Health Network — Not referred.

Auxiliary — Not referred.

MAG Mutual Insurance Company and Supplemental Report — Not referred.

### **Reports of Committees**

Access to Medical Care — Not referred.

Auxiliary — Not referred.

Cancer — Not referred.

Constitution & Bylaws — Not referred.

C & B Supplemental Report — Referred to Ref. Comm. C & B.

Continuing Medical Education — Not referred.

Emergency Medical Services — Not referred.

Impaired Physicians — Not referred.

Legislative Council — Referred to Ref. Comm. C.

Maternal & Infant Health — Not referred.

Medical Aspects of Sports — Not referred.

Medical Practice — Referred Rec. 1 to Ref. Comm. B and Rec. 2 to Ref. Comm. C.

Medical Schools — Not referred.

Medicine & Human Values — Referred to Ref. Comm. A.

Membership Expansion & Involvement — Not referred.

Non-Physician Health Care Providers — Referred to Ref. Comm. A.

Prison Health Care — Not referred.

Public Health — Referred to Ref. Comm. B.

Public Relations — Referred to Ref. Comm. F.

Scientific Assembly — Not referred.

Specialty Society Relations — Not referred.

Third Party Payors — Referred Rec. 1 to Ref. Comm. C and Rec. 2 to Ref. Comm. B.



*Dr. William C. Collins, of Atlanta, who won the race for President-Elect of MAG against Dr. Richard A. Cohen, of Austell, is shown here distributing campaign hats.*



Ad Hoc for Tort Refort — Not referred.

Ad Hoc Committee on Diversion of Legitimate Prescription Drugs — Not referred.

Ad Hoc on PRO Review — Not referred.

Ad Hoc on Senior Citizen Advocacy — Referred Rec. 1 to Ref. Comm. B, Rec. 2, 7 to Ref. Comm. D, and Rec. 3, 4, 5, 6 to Ref. Comm. F.

## Resolutions

Banning of Tobacco Product Advertisement — Res. 1: Referred Rec. 1 to Ref. Comm. D and Rec. 2 to Ref. Comm. C.

Financial Structure of the *JMAG* — Res. 2: Referred to Ref. Comm. F.

Committee Chairmanship — Res. 3: Referred to Ref. Comm. C & B.

Medical Examiners System — Res. 4: Referred to Ref. Comm. C.

Stratified Licensure — Res. 5: Referred to Ref. Comm. C.

Student Member of Board of Directors — Res. 6: Referred to Ref. Comm. C & B.

Student Members of Committees — Res. 7: Referred to Ref. Comm. C & B.

Section Recognition of Services — Res. 8: Referred to Ref. Comm. D.

Student Section Representative — Res. 9: Referred to Ref. Comm. C & B.

(Resolutions 10 & 11 were withdrawn.)

Third Party Payor Claims — Res. 12: Referred to Ref. Comm. B.

Identification of Tobacco as a Cause of Death — Res. 13: Referred to Ref. Comm. C.

Prompt Payments in Insurance Claims — Res. 14: Referred to Ref. Comm. C.

Allocation of MAG dues for *JMAG* — Res. 15: Referred to Ref. Comm. F.

Proposal to Amend the Acquired Immune Deficiency Syndrome Legislature Act — Res. 16: Referred to Ref. Comm. C.

Unified Membership with AMA — Res. 17: Referred to Ref. Comm. A.

Fiscal Solvency of Insurance Companies — Res. 18: Referred to Ref. Comm. B.

Peer Review Contract with Board of Medical Examiners — Res. 19: Referred to Ref. Comm. C.

Voluntary Acceptance of Medicare Assignment — Res. 20: Referred to Ref. Comm. B.

State Funding of Grady Memorial Hospital — Res. 21: Referred to Ref. Comm. C.

Labeling to Better Identify Prescribed Medications — Res. 22: Referred to Ref. Comm. C.

Commendation of Louis W. Sullivan, M.D. — Res. 23: Referred to Ref. Comm. D.

Organizational Evaluation — Res. 24: Referred to Ref. Comm. A.

Informed Consent — Res. 25: Referred to Ref. Comm. C.

National Health Insurance — Res. 26: Referred to Ref. Comm. B.

Elimination of Penalty for Reinstatement into Membership — Res. 27: Referred to Ref. Comm. C & B.

Duties of Executive Director — Res. 28: Referred to Ref. Comm. C & B.

Qualifications of Life Membership — Res. 29: Referred to Ref. Comm. C & B.

Duties of Executive Director — Res. 30: Referred to Ref. Comm. C & B.

National Accreditation of CME — Res. 31: Referred to Ref. Comm. D.

Freedom of Choice of Health Insurance — Res. 32: Referred to Ref. Comm. C.

MAG Roster — Res. 33: Referred to Ref. Comm. A.

Legalization of Drugs. — Res. 34: Referred to Ref. Comm. C.

AEtna Lawsuit — Res. 35: Referred to Ref. Comm. A.

Hospital Medical Staff Section — Res. 36: Referred to Ref. Comm. C & B.

Amendment to Articles V, VI & XI of the Constitution — Res. 37: Referred to Ref. Comm. C & B.

Executive Session — Res. 38: Referred to Ref. Comm. C & B.

Special Rules of Procedures of the House of Delegates & The Board of Directors — Res. 39: Referred to Ref. Comm. C & B.

Increase the Size of the Committee on Finance — Res. 40: Referred to Ref. Comm. C & B.

Specialty Society Representation — Res. 41: Referred to Ref. Comm. C & B.

Nursing Homes and Personal Care Homes — Res. 42: Referred to Ref. Comm. C.

Battered Women — Res. 43: Referred Res. 1, 3 to Ref. Comm. C and Res. 2 to Ref. Comm. F.

Creation of an At-Large Membership Category — Res. 44: Referred to Ref. Comm. C & B.

Investigation of Hospital Practices — Res. 45: Referred to Ref. Comm. B.

Medical Regulations — Res. 46: Referred to Ref. Comm. B.

Inflammatory Language Contained in Medicare Regulations — Res. 47: Referred to Ref. Comm. C.

Medical Program — Res. 48: Referred to Ref. Comm. B.

## Appointments of Reference Committees

The speaker announced the appointments of the House of Delegates Reference Committees as follows:

### Reference Committee A

Dan B. Stephens, Chairman, Cobb; Albert A. Carr, Vice Chairman, Richmond; Roy W. Vandiver, DeKalb; Charles W. McDowell, Jr., DeKalb; Dent W. Purcell, Georgia Medical; Gerald E. Sanders, Cobb; Asa G. Yancey, Medical Association of Atlanta; Anthony F. Isele, Dougherty; Joyce Butler, MAG Staff.

### Reference Committee B

Hugh S. Thompson, Jr., Chairman, Medical Association of Atlanta; O. Wytch Stubbs, Jr., Vice Chairman, DeKalb; Dolford F. Payne, Jr., Medical Association of

## First Session-House of Delegates

Atlanta; Virgle W. McEver, III, Peachbelt; Robert Glenn Carter, St. Johns Parrish; William A. Wolff, Muscogee; Alfred L. Davis, Jr., Waycross; John S. Antalis, Whitfield-Murray; Cam Taylor, MAG Staff.

### Reference Committee C

James L. O'Quinn, Chairman, Richmond; Ellis B. Keener, Vice Chairman, Hall; William G. Whitaker, III, DeKalb; William B. Jones, Hall; William L. Dobes, Jr., Medical Association of Atlanta; Catherine S. Andrews, Cobb; Ronald P. Roper, Cobb; Joseph V. Morrison, Jr., Georgia Medical; Joe Wood and Donna Glass, MAG Staff.

### Reference Committee D

J. Robert Logan, Chairman, Georgia Medical; Spencer S. Brewer, Jr., Vice Chairman, Medical Association of Atlanta; Robert A. Burns, Whitfield-Murray; Kenneth L. Goldman, Muscogee; Rodrigo Cabezas, Medical Association of Atlanta; Thomas L. Haltom, Cobb; Jim Lee Rogers, Floyd-Polk-Chattooga; John A. Hudson, Bibb; Steve Davis, MAG Staff.

### Reference Committee F

H. Duane Blair, Chairman, DeKalb; Alva Louie Mayes, Jr., Vice Chairman, Bibb; Alan Plummer, Medical Association of Atlanta; Donald H. Campbell, Cobb; Walter M. Ligon, Cobb; Ellis H. Nelson, Richmond; Karen Haughey, Etta Peoples, MAG Staff.

### Reference Committee on Constitution & Bylaws

Joy A. Maxey, Chairman, DeKalb; James F. Beattie, Jr., Vice Chairman, Walker-Catoosa-Dade; John T. Yauger, Medical Association of Atlanta; E.M. Molnar, Muscogee; Joe C. Stubbs, South Georgia; Luther M. Thomas, Jr., Richmond; Leon H. Bush, Richmond; Jim Moffett, Lynn Pearson, MAG Staff.

### Adjournment

After several brief announcements, the Speaker adjourned the First Session of House of Delegates at approximately 10 PM.



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# Unreferred Reports

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## REPORT OF THE PRESIDENT

**Joseph P. Bailey, Jr., M.D.**

**T**his year has been one of great challenge and tremendous satisfaction for me. There have been many challenges, yet each has led toward creating a better Medical Association.

The creation of a Blue Cross/Blue Shield Liaison Committee which meets four times a year has provided us with interchange between our organization and leadership of this important health care carrier in our state.

This year's Legislative Seminar held at the Radisson Jekyll Island Club on August 19-21, 1988 was again a highly successful activity resulting in improved relationships between legislators and our organization and also providing considerable insight for the attendees into the legislative process.

There was an Ad Hoc Committee on Senior Citizens Advocacy Program developed in July, 1988, and chaired by Dr. Joe Nettles. This committee will be extremely important in the development of increasingly positive relationships between us and this expanding segment of our Society.

Your medical society played a major role in the extension of the penalty period for medical license renewal to August 31, 1988 on the part of Medical Examiners. Had this not been accomplished, many qualified physicians in the State of Georgia would have been subject to considerable difficulty in the renewal of their licenses.

A significant action occurred in the Summer of 1988 with the Attorney General's ruling on the activities of nurses in the Public Health Clinics of our State which in general terms stated that the prescribing and dispensing of medications by the nurses in these clinics constituted the practice of medicine and therefore was unlawful. This culminated in meetings between your organization and the Department of Human Resources, the Georgia Nursing Association and the Georgia Board of Nursing in an attempt to develop a "Nurse protocol" legislative proposal as well as the consideration of a major revision of the Nurse Practice Act. Subsequently, legislative activity was addressed solely to the consideration for nurse protocols and culminated in the passage of House Bill 209 in version that was favorable to our position of providing quality health care.



Legislative Council size and activity under the leadership of Dr. James Kaufmann was expanded and two Vice-chairmen were appointed as per the actions of last year's House of Delegates, those two being Dr. Joe Nettles, President-Elect, and Dr. Jack Menendez, Immediate Past President. It is felt that this Council served admirably in providing a mechanism for discussion and plans of legislative activity in the General Assembly in 1989, as well as providing a formal and very beneficial liaison with specialty societies.

A major problem this year was the development of a mechanism for implementation of the informed Consent Law. This resulted in major activity for all segments of our Association and particularly enhanced the relationship with MAG Mutual, which is vitally concerned with the issue of informed consent. It also provided a forum for interchange with the specialty societies. Of particular note is the major role that Our General Counsel, Mr. Richard Greene, played in the development of not only the proposals concerning the rules themselves but the subsequent educational activities that were disseminated throughout the State of Georgia.

A revised job description for the Medical Director of the Medical Association of Georgia's Impaired Physicians Program was developed and attempts at obtaining the services of the previously proposed individual were unsuccessful.

Of significance was the meeting held with the Georgia Academy of Family Physicians leadership in the Summer of 1988. This had led to several subsequent meetings and it is felt that the relationship between our organizations is now very strong and positive, thanks in great part to the cooperative spirit of their President and MAG member, Dr. Richard Wherry.

The Auxiliary to the Medical Association of Georgia received unusual distinction in being recog-

nized by the National AMA Auxiliary for its positive interaction with MAG. This led to two presentations in Chicago by Mrs. Jan Collins, President of the Auxiliary, in conjunction with your President. These presentations on organizational teamwork to the AMA Auxiliary Leadership Conference were given on October 9, 1988 and February 5, 1989.

Your President attended an AMA meeting on RBRVS on November 13, 1988 in Chicago. This meeting dealt primarily with the dissemination of information about RBRVS and did not provide definitive conclusions as to the position of AMA on RBRVS.

Dr. Bill Waters chaired a very successful conference on medical education at the Doubletree Hotel in Atlanta on October 14-15, 1988.

Your leadership met with representatives of the Pediatric Specialty in Georgia and developed a legislative approach to require health insurance coverage for "well children services." Legislation has been introduced in the General Assembly supporting this effort and will be pursued in 1990.

Of signal significance this year was the selection of Dr. Louis O. Sullivan as Secretary of Health and Human Service by President George Bush and Dr. Sullivan's subsequent confirmation by the Senate Committee and the full Senate. Dr. Sullivan's nomination and confirmation was strongly supported by your organization. I know that everyone joins me in the deep sense of pride in having a member of the Medical Association of Georgia in this extremely important governmental position.

The Leadership Conference was held at the Waverly Hotel on January 28-29, 1989, and this year had a different format. Legislators actively involved in the current General Assembly made presentations, including Mr. Thomas Murphy, Speaker of the House of Representatives. Also, we were favored to

have the President-Elect of the American Medical Association, Dr. Allen Nelson, make a presentation. Dr. Murray Freeman, President of the Georgia Obstetrical and Gynecological Society, gave an excellent talk on the obstetrical liability crisis. We also were greatly honored to have our U.S. Senator, the Honorable Wyche Fowler, make an excellent presentation. As a part of this year's Leadership Conference a program was given by Mrs. Mary Lou Stephens and Mrs. Julia Von Haam on Parliamentary Procedure. This program was overbooked in attendance and was, indeed, excellent, providing our organization's leadership with insight into the issues of parliamentary procedure.

Your organization has been active in the development and support of the PADS II (Pharmaceutical Analytical Data System) program and has been involved with presentations by Mrs. Bonnie Wilford of the AMA to state leadership concerning this vital matter directed at diversion of legitimate drugs to illegal use in our state.

This year has also been associated with a very strong and positive working relationship with the Georgia Medical Care Foundation and we are especially indebted to Dr. Ralph Murphy for his leadership role as its Director. This area of medicine dealing with utilization review is vital to us and it is becoming increasingly obvious that having an organization in our state headed by a physician is essential.

We have spend great effort and time addressing the issue of the OBRA provisions of 1985 dealing with non-payment for substandard care. This issue has tremendous negative implications and has a specific negative implication concerning increased exposure to medical liability suits. Efforts have been developed to try to modify those factors in this program that will be implemented but the with background approach being to repeal this onerous law.





*Jan Collins (Mrs. William C.) (L), 1988-89 President of the Auxiliary to MAG, receives recognition from the new 1989-90 Auxiliary President Grace Walden (Mrs. Charles W.) for her outstanding accomplishments during her year as president.*

A major problem of crisis proportions has been the insurance carrier change for Medicare in the State of Georgia. This change at the first of the year was from Prudential to the Aetna Insurance Company. The base of operation for this program is in Savannah, Georgia and your leadership has met with the director of the program in Savannah and as well with the utilization review organization Aetna contracted with, HealthCare Compare, which is based in Chicago, Illinois. In our meetings with them we found a tremendous backlog of unprocessed claims; we found difficulties related to access to their organization and also found that the method of evaluating claims had changed without conveyance to the physicians of the state what those changes were. We have addressed these issues and are continuing to do so, recognizing the vital character of the Medical payment system to most physicians in this state. It is my sincere hope that by the time of our House meeting there will have been better resolution of the *untenable* situation.

Mr. Paul Shanor has been appointed Interim Executive Director

of our organization and under his leadership we have had a meeting of the county medical society executives which was held on January 27, 1989. It is planned that these meetings will be continued on a regular basis. In addition, Mr. Shanor has developed job descriptions for the major positions in our organization and is having regular meetings of the staff of the Medical Association of Georgia. His contributions to our organizations have been exemplary and are deeply appreciated by all.

This year's legislative activity headed by Mr. Richard Greene and supported by Mr. Paul Shanor and Mr. Joe Wood, under the direction of Dr. James Kaufmann has truly been exemplary. The effort and time required of these individuals in the development of support for the position of medicine in our state is beyond belief. I am sure that I join with every member of the Association in thanking each of them for these efforts.

Starting in the Spring of 1988, a major problem developed for some thirty of our obstetrical and gynecologic colleagues in Savannah, Georgia. These physicians and/or

their office managers have been either subpoenaed or requested to give testimony before a Federal Grand Jury concerning the possible anti-trust violation of price fixing. The potential criminal penalty in this matter is three years in jail and/or a \$250,000 fine per physician. In addition, each of these physicians have been required to retain individual legal representation because of the criminal character of the allegation. They have been required to submit their office records to the Federal Grand Jury and many of their office managers have been subpoenaed to give testimony. The cost of this activity has been tremendous and may rise to ever greater amounts pending the findings of this Grand Jury and the question of indictment. Your organization has actively pursued this issue, trying to find mechanisms whereby meaningful help could be provided. Your President and Mr. David Poythress from the Georgia Health Network went to Savannah and met with the physicians involved. In addition, at the AMA House of Delegates meeting in the Summer of 1988, your President made a presentation to Mr. Rick Rule, Head of the Anti-Trust Division of the U.S. Justice Department, concerning the dire consequences of the actions that were being considered and taken in regards to the physicians in Savannah. At that time a delegation of MAG officers and staff including your President-Elect and MAG's General Council also met with Mr. Kirk B. Johnson, General Counsel for the American Medical Association seeking their active support. Subsequently, Mr. Richard Greene, Mr. Paul Shanor and your President, along with Dr. Joe Nettles and Dr. Roland Summers, met with Mr. Kirk Johnson, Mr. Ed Hirshfield (AMA), Mr. Jack Miles and Mr. Jack Bierig on Saturday, February 2, 1989, at the AMA Leadership Conference in Chicago. All of these individuals are attorneys who have specific interest and information about anti-trust



matters. Mr. Rule was subsequently replaced in the Justice Department. One of the efforts we decided would be important was to meet with his replacement and either the Attorney General or his representative as soon as possible. In addition, Mr. Johnson felt that the development of a central resource such as a clearing house for information for the attorneys representing the physicians in Savannah would be of value. Another issue that has come to the forefront is a method by which financial support for our colleagues in Savannah can be developed. It has been decided that in the event of indictment an effort will be immediately launched for a voluntary relief fund for these physicians. The character of this type of activity on the part of the Justice Department carries high levels of cost in money, time and tremendous frustration and vexation for those physicians involved. Physicians have not maintained high levels of understanding about such items as the Sherman Anti-Trust Law and this type of activity has been foreign to our membership. It is, therefore, highly upsetting to suddenly have intervention taken against us as has been done in Savannah. You can be assured of our continued interest and support in every way possible for these physicians.

Your leadership has continued to meet with the Georgia Hospital Association leadership and the mutual interchange between these two organizations has again provided ongoing and positive association and support.

A presentation was made to Mrs. Barbara Thibodeau on November 7, 1988 on the occasion of her installation as President of the Auxiliary to the Southern Medical Association. A letter of congratulations was read supporting her from then President-Elect George Bush.

GaMPAC, under the leadership of Dr. Barbara O'Quinn, has made notable and positive inroads into the legislative activities in our state and

he and the GaMPAC Board are to be congratulated for the excellent effort in the development of this vital program to the Medical Association of Georgia.

An issue that is vital to us is the inclusion of specialty society representation in our organization. This year has proven that it is absolutely essential for the Medical Association of Georgia to have immediate, positive and ongoing relationships with the leadership of each of the specialty societies. This report is tendered, therefore, with strong support for the motion that lays on the table at this time supporting specialty society membership in the House.

1988-1989 has been a year of great challenge, great opportunity and great privilege for me as your President. It has been truly an honor that is the highlight of my life and will never be forgotten. I'm confident that the acts taken during this year were in support of our organization and will prove to be of great value to us. The long-term course of our organization will continue to move to support the patient through organized medicine and by virtue of this support guarantee the position of the physicians in our state. The professional character of medicine is the highest calling that one can turn to in our world today. It is mandatory that we pursue the maintenance of this position and that we inform the public about our desires, interests, and objectives and goals. This process of dissemination of information has to be conducted in a fashion consistent with the professional character of medicine and be dedicated to support of the human condition. In a non-altruistic society, it is with great difficulty that a large profession such as ours continues to strive for altruistic principles, and yet, that is what we must do.

On the occasion of tendering this report I wish to thank each and every individual in our organization for their support, not of me, but of

medicine; of the fundamental principles that drove each of us to work to obtain the education and abilities to bring good to our fellow man.

I thank you for this wonderful opportunity and great honor.

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### CHAIRMAN OF THE BOARD

**William C. Collins, M.D.**

**T**he Board of Directors of the Medical Association of Georgia is now and has been functioning quite well in carrying out its designated activities according to our Constitution & Bylaws.

It is now made up of 50 odd members of MAG plus additional attendees who are present as non-voting members that bring the average board meeting to between 75-100 people, representing every possible aim of medicine and its ancillary subsidiaries.

The work of the Board is in my humble opinion the backbone of the Medical Association of Georgia. The voting members and alternates are elected representatives geographically and to some extent demographically selected from throughout the great State of Georgia. In the past year the Board has met in Augusta, Columbus, St. Simons and Atlanta in an effort to bring its meetings close to the doctors and the local societies so as to make their participation and input easier through better access.

At a typical meeting the Board hears and approves or disapproves of the actions of the Executive Committee, the Auxiliary, the individual officers, the standing committees, any ad hoc or special committees with pertinent reports and the full time administrative staff. It is through this activity that the Board monitors or carries out the actions of the House of Delegates and responds to new problems that come up during the year.



Reports from ancillary organizations such as the Georgia Medical Care Foundation, MAG Mutual Insurance Company, St. Paul Insurance Company, Georgia Health Network, GaMPAC, Blue Cross-Blue Shield, the Georgia Hospital Association and the Georgia Pharmaceutical Association, keep Board members briefed on what is happening in these important areas.

In the past year, the presidents of most of the larger specialty society organizations have been asked to attend a meeting of the Board and present ideas or problems to the Board that they deem important to their members.

The Board has continued to delve into matters in great detail that have been referred to it by the House of Delegates for action and to act as a referral post for new matters needing committee attention.

By receiving input from the county societies through their members and their executive directors and by having most of the AMA delegation present for its deliberations, the Board serves as a continual conduit for ideas and information to flow easily in a timely fashion both up and down the channels of the Association.

In conclusion, as the Chairman of the Board for the past 3 years, it is my pleasure to:

(1) report to the House of Delegates that all business and actions referred to the Board have been handled in a timely and appropriate manner;

(2) report to the House of Delegates that the members of the Board have been faithful in their attendance and deliberations and in representing their respective constituents;

(3) report that the geographical dispersal of Board meetings has brought MAG to most every section of the State of Georgia and that this will be continued on a rotating basis;

(4) report that the specialty societies will continue to be encour-

aged to come present any concerns or special problems to the Board on a yearly basis;

(5) and finally, report that the Board of Directors continues to serve as an important link between the House of Delegates and the Executive Committee, between county societies and the AMA, between MAG and its ancillary offshoots and between MAG and other professional organizations.

In short, this portion of your organization is alive and well and its dedicated members are to be congratulated for a job well done!

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### REPORT OF THE SECRETARY

Ralph A. Tillman, M.D.

Secretary's Diatribe 4/5/89  
2:30 A.M.

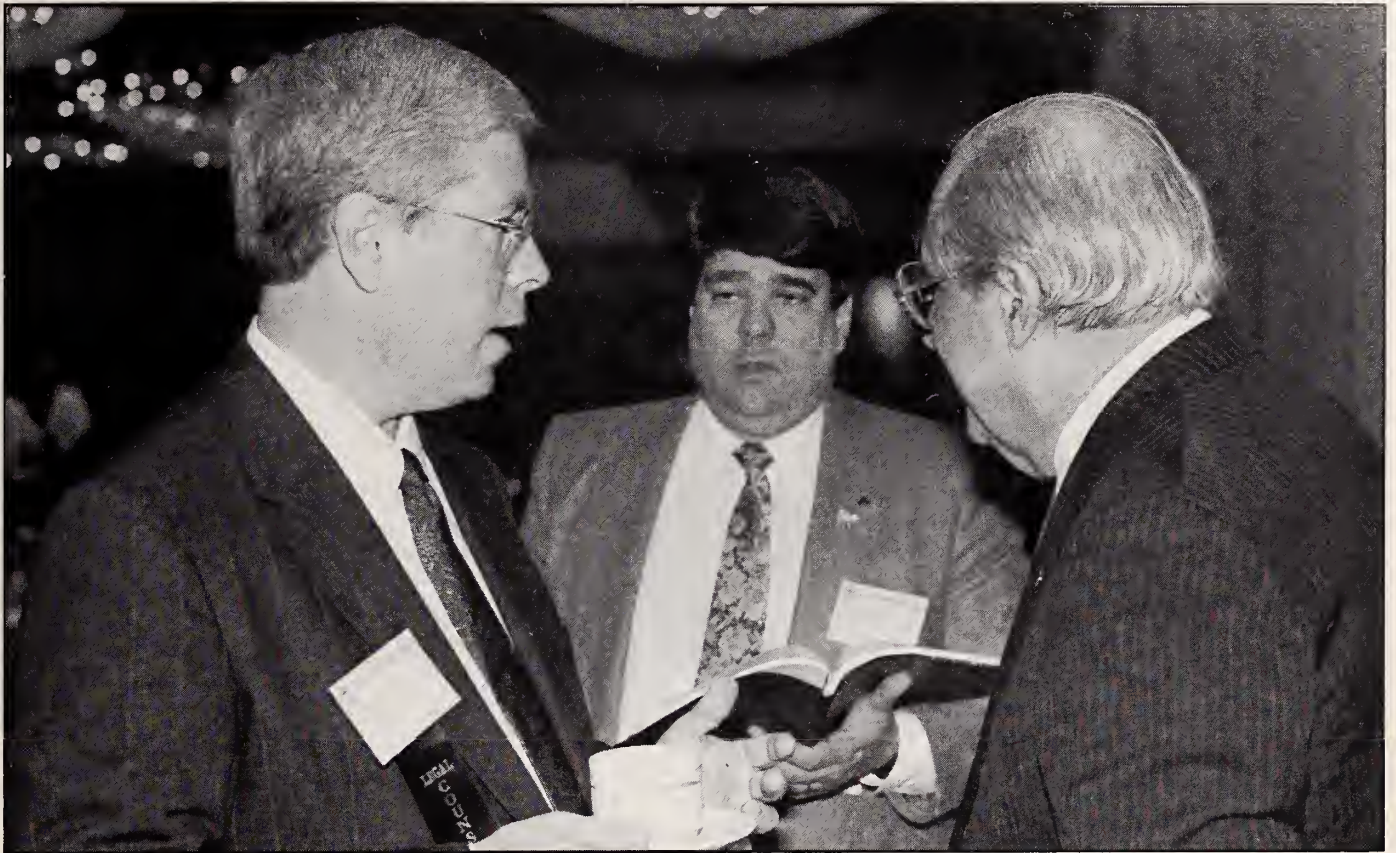
Another one of my many sleepless nights; perhaps not as frequent as they have been at times, but they do occur with annoying frequency and are bothersome and aggravating — more so to Wilma than me, because obviously my inability to sleep creates sleepless hours for her as well. While thumbing through recent issues of magazines I never seem to find the time to read any more — *Audubon*, *Smithsonian*, *Nature Conservancy*, *National Geographic*, *National Gardening*, *Horticulture News*, etc. — the thought suddenly hit me — “write your report, dummy, you have procrastinated long enough!” As I get older, I seem to have become more of a procrastinator (as well as an insomniac) and may well be getting close to the philosophy of a young obstetrician friend, Dr. Kevin Daus (my replacement in the Atlanta OB/GYN Group). He says, “one should never do today anything that can be put off until tomorrow” — the Scarlett

O'Harian approach to life and maybe one that is not all bad.

We are about to complete another somewhat discouraging year for the House of Medicine — a year that has brought about changes none of us could have possibly anticipated a few short years ago. There apparently is an “evil force” that is working overtime on a long, well-planned and orchestrated course to make life miserable for those of us who — for whatever motivating factors — have chosen to devote our lives to the medical profession. I'm certain that we will be given the opportunity to participate in discussion on some of those “forces” at the upcoming annual MAG House of Delegates: third party payor intervention (governmental as well as commercial insurers); pre-paid alternative health care delivery systems (others as well as our own creation); health care needs of the indigent and uninsured membership-related problems; professional liability costs and related factors; legislatively created problems and legislation sorely needed; drug and crime-related social ills that are destroying the very fiber of this nation; environmental problems that we can't seem to get a handle on; taxes, taxes, and more tax confusion as we continue to increase our national indebtedness; complexities of life that make for a less “content, happy and gentler society,” etc., etc. By George, I think I have hit upon the etiology of my insomnia!

My fourth year as the Secretary of the MAG has been a busy one — one that, among other things, has seen the dawning of a new era under the guidance of a new Executive Director, Mr. Paul Shanor. Mr. Shanor has been with us since December, 1987 and has done a thoroughly satisfactory job in any capacity in which he has served us — in particular, and most recently, as our Interim Director for the past four months. Paul is just the third executive director this organization





(L to R) Richard Greene, MAG Legal Counsel, Paul Shanor, MAG Executive Director, and James Kaufmann, M.D., Speaker of the House.

has had in the past 17 years and only a few of our *older* active members can remember beyond Mr. James Moffett who has promoted to that position in May, 1972. Given the opportunity and support I sincerely believe Mr. Shanor will provide creative administrative guidance for a long, successful and productive tenure with the MAG.

We are indeed fortunate in having some excellent, dedicated people on board who are willing to devote long arduous hours in our behalf and they deserve our love, accolades and support. With some trepidation and recognizing that I may unintentionally overlook a few, I would like to mention James Moffett, Joyce Butler, Richard Greene, Steve Davis, Talitha Russell, Cam Taylor, Lynn Pearson, Susan Dillon, Etta Peoples, Donna Glass, Dorothy Parker, Joe T. Wood, Dan Kohn, Ray Williams, a host of lovely assistants, secretaries and receptionists (Nicki Hernandez), and one to whom I am deeply indebted, Millie Pierce

Fowler. Please pass along a word of praise and encouragement to them from time to time — a smile and pat on the back will make both them and you feel better. One we will all miss and to whom we wish the very best of everything is Sherry Marsh — a recent new mother.

I have served through the administrations of four presidents — Drs. Logan, Watson, Menendez, and Bailey — and now am looking forward and planning for the fifth, with Dr. Joseph Nettles. Each year has brought along new approaches to problems — mostly old problems getting more complex, but always some new ones intermingled with the old. This upcoming year will be no different; there are challenges we must face and hard decisions we must make — and make them we shall! Hopefully, most of those decisions will be *wise ones* and in tune with the desires of the membership of this fine organization. We should always continue to strive towards increasing our membership,

dedication, involvement and commitment and together as a unified “good force” work towards overcoming all of the “evil forces” that prevent us from genuinely enjoying our efforts at providing the highest quality medical care to all of our citizens, at a cost that is reasonable and affordable to society and the individual recipient.

Let me thank you for the opportunity granted me to serve you as your Secretary for the past four years. They have honestly produced some genuine pleasure and I look forward to my fifth and final year. I have served with some very fine and dedicated people whom I have come to respect and admire as they attempted to serve you and all of the House of Medicine and its needs. I apologize for making this “report” (?) longer than it should be — now it’s time to go back to bed and attempt to sleep an hour or two.

## MEMBERSHIP COMPARISON

	1988	1987	1986	1985	1984
Active	5421	5351	5208	5056	4879
Active Resident	365	538	376	357	125
Affiliate	7	7	7	7	7
Associate	52	64	58	62	53
DE-1 (financial hardship/illness)	59	58	54	48	48
DE-2 (post-graduate training)	2	2	2	2	3
DE-4 (temporary military)	1	2	2	2	4
DE-5 (life)	349	325	262	257	264
DE-7 (senior members, over 70)	58	35	89	87	74
Retired	364	325	304	241	197
Service	36	52	56	62	63
Student	208	141	93	50	6
	6922	6900	6511	6231	5723
AMA MEMBERSHIP*	3457	3403	3289	3416	3776

\*The above AMA membership figures reflect only those AMA members who pay AMA dues via MAG.

## FIRST DISTRICT MEDICAL SOCIETY

Gary Loveless, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Ogeechee River Emory Smith, Statesboro	38	31	45	31
Burke Pamela T. Stitt, Waynesboro	7	4	6	3
Emanuel T.M. Tamblyn, III, Swainsboro	6	3	6	3
Laurens Andy F. Williamson, Dublin	48	26	45	22
Screven (no officers)	1	0	0	0
Southeast Georgia Hubert M. Suber, Vidalia	22	4	20	4
St. Johns Parish Grace C. Bautista, Hinesville	10	2	9	2
	132	70	131	65

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]



## SECOND DISTRICT MEDICAL SOCIETY

W. Charles Pfister, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Colquitt	30	15	33	16
Norman Reese, Moultrie				
Decatur-Seminole	15	11	19	12
K. Dean Burke, Bainbridge				
Mitchell	5	3	5	2
A.A. McNeill, Jr., Camilla				
Southwest Georgia	12	4	11	4
Virendra M. Saxena, Fort Gaines				
Thomas Area	60	38	62	38
W.A. Lardin, Thomasville				
Tift	51	27	54	27
Roger McLendon, Tifton				
Worth	4	3	4	1
H.G. Davis, Jr., Sylvester				
	177	101	188	100

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## THIRD DISTRICT MEDICAL SOCIETY

V.W. McEver, Jr., M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Flint	13	4	13	4
John B. Adams, Jr., Cordele				
Peachbelt	51	36	56	38
Manoj H. Shah, Warner Robins				
Randolph-Stewart-Terrell	3	1	4	1
Emilio Delgado, Dawson				
Sumter	25	13	26	17
William R. Anderson Americus				
	92	54	99	60

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## DEKALB MEDICAL SOCIETY

Charles McDowell, Jr., M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
DeKalb Gary Botstein, Decatur	320	184	306	181

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## MEDICAL ASSOCIATION OF ATLANTA

William C. Collins, M.D., Director

T.J. Anderson, Jr., M.D., Director

J. Harold Harrison, M.D., Director

Jeffrey T. Nugent, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
M.A.A. William M. McClatchey, Atlanta	1888	989	1750	984

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## SIXTH DISTRICT MEDICAL SOCIETY

Werner A. Linz, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Coweta Joe W. Parks, III, Newnan	31	19	32	18
Henry (no officers)	5	3	3	2
Meriwether-Harris-Talbot James Knowles, Warm Springs	9	4	9	4
Spalding S.G. Patel, Griffin	52	22	51	18
Troup J. Connor Smith, LaGrange	58	47	65	52
Upton James K. Elsey, Thomaston	26	9	24	9
	181	94	184	103

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]



## SEVENTH DISTRICT MEDICAL SOCIETY

B.L. Harbin, Jr., M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Bartow John T. Perry, Cartersville	12	7	15	8
Carroll-Haralson Frederick Martin, Carrollton	4	25	38	21
Gordon Richard Gusso, Calhoun	21	8	22	7
Douglas Joseph Bussey, Douglasville	23	10	25	15
Walker-Catoosa-Dade M. Clark Colvard, Ft. Oglethorpe	44	2	44	26
Whitfield-Murray Stefan D. Fromm, Dalton	79	66	81	64
	<u>223</u>	<u>118</u>	<u>225</u>	<u>141</u>

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]



(L to R) Dr. Hugh Thompson, Jr., a delegate from the Medical Association of Atlanta, Jim Moffett, MAG's Director of Specialty Society Relations, and Priscilla Daves, MAG's Director of Public Relations.

## EIGHTH DISTRICT MEDICAL SOCIETY

Joe C. Stubbs, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Altamaha B.S. Patel, Baxley	8	3	7	4
Ben Hill-Irwin William J. Hammond, Fitzgerald	8	8	9	9
Coffee Thomas C. Nation (Pres.), Douglas	12	5	12	3
Camden-Charlton Joseph D. Proctor, Jr., Kingsland	16	5	11	4
Glynn Turner W. Rentz, Brunswick	77	41	80	41
Ocmulgee Titus A. Taube, Cochran	20	12	20	13
South Georgia Donald J. Mirate, Valdosta	90	38	89	43
Ware S. William Clark, III, Waycross	54	29	60	29
Wayne Ollie O. McGahee, Jr., Jesup	12	2	16	2
	297	143	304	148

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## NINTH DISTRICT MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Barrow William T. MacNew, Jr., Winder	11	3	11	5
Blue Ridge Robert A. Burns, Blue Ridge	11	4	11	4
Elbert Roger David Mize, Elberton	9	6	8	6
Gwinnett-Forsyth Rupert H. Bramblett, Cumming	96	46	106	53
Cherokee-Pickens John A. Cheek, Canton	21	10	27	11
Habersham F. Stuart Sanders, Clarkesville	11	6	11	6
Hart J.R. Merrill, Hartwell	5	1	6	2
Jackson-Banks Susan Alexander, Commerce	9	6	8	6
Lumpkin Van B. Elliot, Dahlenega	9	5	9	5
Stephens-Rabun David Walker, Lavonia	32	8	35	7
	214	95	232	105

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]



## TENTH DISTRICT MEDICAL SOCIETY

William M. Headley, M.D., Director

Counties and Secretaries	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Baldwin	51	24	47	22
Jose A. Delgado, Milledgeville				
Franklin	5	4	6	4
Hoyt Crump, Royston				
Jefferson	3	0	0	0
(no officers)				
McDuffie	3	3	2	1
M. Frank Powell (Pres.), Thomson				
Newton-Rockdale	45	20	49	22
Millard I. Ross, Conyers				
Oconee Valley	12	3	9	2
Rakesh Kumar, Eatonton				
Walton	20	12	17	7
Lisa Vickery (Pres.), Monroe				
Washington	6	1	7	1
Earle M. Taylor, Sandersville				
Wilkes	5	4	4	3
John E. Pollock, Washington				
	150	71	141	62

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## BIBB COUNTY MEDICAL SOCIETY

Charles A. Lanford, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Bibb	354	233	358	235
Bruce S. Allen, Macon				

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## CLAYTON-FAYETTE COUNTY MEDICAL SOCIETY

Selwyn T. Hartley, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Clayton-Fayette	124	51	130	55
Michael Di Cristina, Riverdale				

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## COBB COUNTY MEDICAL SOCIETY

Dan B. Stephens, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Cobb H. Wayne Tempelton, Austell	355	200	369	213

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## CRAWFORD W. LONG MEDICAL SOCIETY

E. Van Herrin, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Crawford W. Long Warren B. Horn, Athens	106	77	120	77

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## DOUGHERTY COUNTY MEDICAL SOCIETY

Carl V. Hancock, Jr., M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Dougherty Van Cise Knowles	151	102	150	102

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]



## FLOYD-POLK CHATTOOGA COUNTY MEDICAL SOCIETY

Joel Todino, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Floyd-Polk-Chattooga John T. Collins, Rome	149	71	144	79

\*Members paying AMA dues via MAG  
[MAG membership figures above reflect active and life members]

## GEORGIA MEDICAL SOCIETY

J. Patrick Evans, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Georgia Medical Society Lawrence E. Ruf, Savannah	290	193	296	198

\*Members paying AMA dues via MAG  
[MAG membership figures above reflect active and life members]

## HALL COUNTY MEDICAL SOCIETY

John H. Reed, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Hall Fred B. Thomas, Jr., Gainesville	133	88	138	93

\*Members paying AMA dues via MAG  
[MAG membership figures above reflect active and life members]

## MUSCOGEE COUNTY MEDICAL SOCIETY

E.M. Molnar, M.D., Director

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Muscogee George B. Hubbard, Columbus	266	151	281	154

\*Members paying AMA dues via MAG  
[MAG membership figures above reflect active and life members]

## RICHMOND COUNTY MEDICAL SOCIETY

**Luther M. Thomas, M.D., Director**  
**James L. O'Quinn, M.D., Director**

County and Secretary	Members 12/31/87		Members 12/31/88	
	MAG	AMA*	MAG	AMA*
Richmond F.C. Ferguson, Augusta	575	285	537	300

\*Members paying AMA dues via MAG

[MAG membership figures above reflect active and life members]

## JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

**Charles R. Underwood,  
M.D., Editor**

**T**he *Journal of the Medical Association of Georgia*, functioning through its Editorial Board, Editor, and Managing Editor, continues as a viable medium of communication between the organizational structure of the Association and its membership. We see our basic mission as providing a forum for the publication of clinical and investigational work done by members of the Association as well as a means whereby political matters, financial concerns, and humanistic issues are brought to the attention of the membership. We continue to strive to improve the quality of the publication as well as producing one that is visually and editorially interesting.

At the time of this 1989 convening of the Annual Session of the MAG, we are confronted in a more significant manner than in the past with the financial strictures placed upon upon us. While inflationary costs of publishing the *Journal*, always carefully and prudently mon-

itored by your editors, continue to put pressure upon us for financial stability, our source of outside income, particularly from national advertising sources, is threatened with significant compromise. We are told by our brokers for national advertising that the many other available channels to obtain such advertising from both pharmaceutical and non-pharmaceutical advertisers is creating ever-mounting difficulty in obtaining such advertising for print media such as our *Journal*. Our national broker for such advertising, the State Medical Journal Advertising Bureau represents the only available source, short of expensively prohibitive individual solicitation of such advertising. We have tried to counterbalance this shrinking source of outside income by utilizing the services of a local broker and thus increasing the amount of local advertising available to us. We would like then to assure the members of the House of Delegates that we are pursuing every available avenue in an effort to be as self sustaining as seems possible or reasonable in the present environment.

It is these fiscal constraints that we would like to bring to the attention of the House of Delegates this year. Not only are the above func-

tions of the *Journal* viewed by your editorial staff as an important mission of the Association and ones which we would like to vigorously continue, but also we would point out that one must understand the position of the *Journal* as a repository of the historically significant course chartered by the Medical Association of Georgia through the years. We would encourage the members of the House of Delegates to give careful consideration to establishing the *Journal* on as firm a fiscal foundation as possible.

Finally, your Editorial Board remains intact and unusually active and cooperative in the carrying on of the functions of the *Journal*. One of our Editorial Board members, Dr. Louis Sullivan has recently moved to Washington, D.C., as head of the U.S. Department of Health and Human Services in the Bush Cabinet. We have invited Dr. Sullivan to continue on our Board, hoping that he will be able on occasion to serve as our "Washington correspondent." Our entire editorial staff wishes to thank the many members of the Association who have been so helpful to us through the past year in maintaining what we hope you view as a quality medical journal and one with which you may in some modest way be proud.

## MEDICAL STUDENT SECTION

**Christine Larsen**

**T**he Medical Student Section (MSS) of the Medical Association of Georgia was under directorship this year by Christine Larsen (Chair from Emory University), Philip Rhyne (Vice-chair from Mercer University) and Lisa King (Secretary-Treasurer from Morehouse School of Medicine). The MSS had several meetings this year and accomplished the following:



1. The major goal for the MAG-MSS was to involve all four medical schools in a state-wide philanthropic project. The Georgia Council on Child Abuse was designated as the recipient of the philanthropy. The Medical College of Georgia has generated \$250. Mercer University and Emory University are completing their fund-raising efforts this spring.

2. AIDS education in the community school systems has also been a major project for the year. The Medical College of Georgia has been successful in working with the Red Cross in conducting multiple educational sessions in elementary and high school classrooms. Emory University has completed several projects in the Atlanta Public School System. Morehouse has trained their medical students and will be conducting educational sessions this spring.

3. The Annual MAG-MSS meeting was held March 11, 1989. Several items of business were accomplished at that meeting.

A. A revised constitution for the MAG-MSS was approved and incorporates new goals and efforts for the group.

B. The budget request for the fiscal year beginning June, 1989 that is submitted to the MAG House of Delegates was approved and reflects the broadened involvement of the students in the MAG and AMA.

C. Several external resolutions were approved and have been submitted to the 1989 MAG House of Delegates. These resolutions included a request for MAG to allow a student member of its Board of Directors, a request for MAG to allow for a student member of Committees of the House of Delegates, a request of MAG to allow the MSS a Delegate to the House of Delegates that shall have the right to make motions and vote, a request for MAG to establish an award to be granted to non-MSS individuals for recognition of service, and a request for MAG to allow for funding

for MAG-MSS students to present medical career information to rural and inner city school students.

D. An *ad hoc* Membership Committee will be developed to promote membership recruitment and to study membership benefits.

E. An *ad hoc* Program Committee will be developed to plan the Annual MAG-MSS meeting.

F. New officers for the next fiscal year beginning June, 1989 were confirmed. Phillip K. Rhyne from Mercer School of Medicine will be the Chairperson. Adela Casas from the Medical College of Georgia will be Vice-Chairperson and Rod Rodriguez from Morehouse will be the Secretary-treasurer.

## YOUNG PHYSICIANS SECTION

**Don H. Campbell, M.D.,  
Chairman**

The bylaws change necessary to create the Young Physicians Section of MAG was initiated at the 1988 House of Delegates Meeting and approved by the Delegates to the House. Bylaws were drafted and adopted by a Governing Council composed of a Chairman, a Delegate to the AMA-YPS and MAG who also serves as a Chairman-elect, a General Secretary, an Alternate Del-



Shown here are Dr. Joy Maxey, of Atlanta, and Georgia Senator Jim Tysinger who received MAG's Certificate of Appreciation for his support of the medical profession.



egate to the AMA-YPS and MAG, a Chairman's Appointee, and 3 Members-at-Large.

The first Young Physicians Section open forum was held in conjunction with the 1988 House of Delegates meeting and heard discussion from over 20 young physicians about issues of particular concern to the physician newly in practice. Of particular interest was concern about contracting issues, alternative delivery systems and federally managed programs such as Medicare.

In June of 1988, the Young Physicians Section was represented at the Young Physician Section of AMA by Drs. S. William Clark, III and Joy Maxey. At that meeting Dr. S. William Clark, III was elected Delegate to the AMA from the Young Physicians Section of AMA. The Georgia delegates introduced a resolution calling on the AMA to ensure language in AMA-sponsored disability insurance programs that would cover inability to work due to a positive HIV test in a physician. That resolution was passed on to the AMA House and referred to a study committee.

In November of 1988, the Governing Council met to hear proposal for activities during the 1989 Leadership Conference. Letters were sent to all physicians in Georgia who met the criteria for membership in the YPS personally inviting them to the Conference. A proposal was also presented to begin a legislator/citizen/physician interaction program modeled after the Colorado Medical Society Internship Program. This program brings citizens and legislators into physicians' offices to spend a day with the physician. The program will be investigated and will be presented to MAG and the Auxiliary for input and support.

During the 1989 Leadership Conference, more than 50 young physicians heard Rep. Jim Pannell from Savannah discuss the importance of legislative involvement for all physicians, particularly those whose

future ability to practice is infringed upon daily by others who seek to practice by statute rather than by education. Guidelines for appropriate physician involvement in the legislative process were discussed and encouraged.

Plans are currently made for the second annual Young Physicians Forum to be held during the 1989 House of Delegates meeting. It is hoped that this Forum will direct the Governing Council to new ways to promote the activities of the Section.

The Young Physicians Section greatly acknowledge the efforts of Steve Davis whose untiring labor kept this Section moving.

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### RESIDENT PHYSICIANS SECTION

**Greg A. Foster, M.D.,  
Chairman**

**T**he Medical Association of Georgia's Resident Physician Section (RPS) represents each and every one of MAG's resident members. As of this writing this includes 327 RPS members, reflecting continued interest by residents of all levels in MAG and its component medical societies.

County societies' efforts remain central to MAG's resident membership. Vigorous recruitment during the past year has been conducted by the Muscogee County Medical Society, the Medical Association of Atlanta, Bibb County Medical Society, Richmond County Medical Society, the Georgia Medical Society, and others. A vital factor in resident membership recruitment is also the cooperation of local teaching hospitals. In several areas of our state, the hospital Director of Medical Education assists in orientation

sessions for residents concerning the benefits of becoming MAG members, the special programs administered by MAG and its Auxiliary, and the importance of becoming involved on a resident level with the leading forces of organized medicine.

This year the MAG Mutual Insurance Company continues its generous offer of paying county and MAG dues for interns and residents joining MAG for the first time. Such generosity will prove to be beneficial not only for those residents who will ultimately practice in Georgia, but also for the component societies of MAG in that they will have the opportunity to nurture residents' involvement in the local chapter before the resident becomes consumed with the running of their private practice.

Once again the challenge before MAG's RPS is to attract from our membership a cadre of residents willing to involve themselves actively in the business of our section and of MAG as a whole. Towards this end the future appears brighter. During the past year, in addition to the annual MAG convention held in Savannah, our section was capably represented at the annual House of Delegates in Chicago and the interim House of Delegates held in Dallas. The residents attending these meetings (Drs. Berman, Easterling, Foster, and Heaton) introduced several important pieces of legislation of which we will certainly hear more in the future. Additionally, the RPS is also proud to announce that its chairman was chosen as a recipient of the AMA/Burroughs Wellcome award which recognizes select residents from across the country for proven leadership abilities and an outstanding dedication to community service.

The RPS has set as its goals for the coming year a continuation of efforts toward securing resident membership in MAG, the development of continued and renewed strong leadership within the RPS,



and the maintenance of resident involvement within MAG.

After this successful past year, the RPS membership and its leaders wish to thank the MAG members, the delegates, and its fine staff for their guidance and assistance in the development and the continued support of the Resident Physicians Section.

## AMA DELEGATION REPORT

**C. Emory Bohler, M.D.,  
Chairman**

### Introduction

**T**he AMA House of Delegates met in Dallas, December 4-7, 1988 with 423 delegates seated including the one new specialty society that was granted a voting delegate at this meeting:

- American Academy of Pain Medicine

The House composition is:

- 336 delegates representing state medical associations
- 77 delegates representing national medical specialty societies
- 10 Section and Service Delegates representing medical students, resident physicians, hospital medical staffs, young physicians, Army, Navy, Air Force, USPHS, and the Veterans Administration.

### Address of the President

James E. Davis, M.D., AMA President, called for continued AMA leadership in addressing the severe shortage of nurses and in dealing with the Resource-Based Relative Value Scale. Calling the AMA-proposed "Registered Care Technologist" an idea whose time has come, Dr. Davis asked for the opportunity

to try it out in order to provide more bedside care givers. Turning to the RBRVS, Dr. Davis urged physicians to "remain unified and not split into warring factions." "American medicine cannot afford a divided profession," he added. "Indeed, if we divide, American medicine will not survive as we know it today."

Dr. Davis also reported on his inaugural challenge to physicians "to tithe four hours a week to community service." He stated that he was pleased with the response. "I have had many favorable communications from physicians, medical organizations, and public groups," Dr. Davis said. "They tell me they agree that physicians need to be more extensively perceived as caring individuals who take a vital part in community life."

### Antitrust Speaker

Charles F. Rule, head of the Antitrust Division of the U.S. Justice Department, gave a major policy speech to the House. He warned the delegates that felony criminal charges will be leveled against competing physicians if they fix fees, allocate patient territories, or boycott insurers. He said that ignorance of antitrust law or belief that actions were undertaken to improve patient care are no defense to criminal antitrust charges.

### Items of Business

The delegates considered 66 reports and 129 resolutions. The AMA's position on the Resource-Based Relative Value Scale clearly dominated the meeting and commanded the majority of the delegates' time and attention.

### Resource-Based Relative Value Study

The Speakers arranged the House schedule so that the RSRVS issue could be discussed alone in the Reference Committee without competing meetings. The discussion continued on Monday and the Reference Committee prepared a re-

port that offered accommodating amendments to the comprehensive Board analysis on the Harvard study.

The House approved the following recommendations:

### Relative Value Scale

1. That the AMA reaffirm its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:

- a. an appropriate RVS based on the resource costs of providing physician services;
- b. an appropriate monetary conversion factor; and
- c. an appropriate set of conversion factor multipliers.

2. That the AMA adopt the position that the current Harvard RSRVS study and data, *when sufficiently expanded, corrected, and refined*, would provide an acceptable basis for a Medicare indemnity payment system.

3. That the AMA work with Harvard, the national medical specialty societies, the PPRC, HCFA, other interested and knowledgeable parties, and the Congress to refine and modify the Harvard RBRVS to ensure that it is technically adequate and can be implemented in a timely and minimally disruptive manner when needed revisions have been satisfactorily completed. Refinement and completion of the RBRVS will require:

- appropriate restudy of the services of specialties when RBRVS data have significant, documented technical deficiencies;
- fundamental improvement of the measurement of practice costs and amortized specialty training costs;
- expansion of the RBRVS to more specialties and services;
- development of an extrapolation method for visits;



- revision, refinement, and expansion of the measurement of pre- and post-work;
- expansion and validation of the extrapolation methodology;
- development of expanded relative value estimates for services for which global fees are customarily utilized as standard definitions are developed and accepted;
- appropriate action to address concerns specific to individual specialties; and
- that the AMA work to establish a mechanism to ensure that additional concerns that may be identified are communicated to and addressed by the appropriate parties and external validation is conducted by the AMA.

## Balance Billing

4. That the Association reaffirm its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medical assignment and its opposition to elimination of balance billing.

5. That the AMA reaffirm its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

6. That the Association promote enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

7. That the Association expand its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

## Transition

8. That a Medicare indemnity payment system be implemented through a blending transition, in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system, or prevailing charges only. The specific transi-

tion period should be chosen in order to strike an appropriate balance between minimizing disruptions for patients and physicians while also minimizing the complexity of the process. In addition, the effects of the new system should be monitored during the transition, with corrections made as needed.

## Geographic Payment Variations

9. That the AMA reaffirm its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

10. That payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan/nonmetropolitan areas within states) based on the availability of high quality data.

11. That geographic differentials should be addressed simultaneously with specialty differentials.

12. That, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

13. That the AMA support the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

a. When the resource costs are substantially different across specialties; and

b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

14. Specialty differentials should apply to all CPT-coded services for which a differential exists.

15. Where specialty differentials exist, criteria for specialty designation should avoid *sole* dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

- Practical completion of a residency plus time in practice;
- Local peer recognition; and
- Carrier analysis of practice patterns.

A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

## Initial Conversion Factor

16. That the Association strongly oppose any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.



## Updating the Fee Schedule

17. That whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience, and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

## Volume and Intensity

18. That the Association strongly oppose implementation of Medicare expenditure targets, which will lead to the rationing of care for Medicare beneficiaries, and instead support constructive approaches to enhancing quality and appropriateness of care.

## Registered Care Technologists (RCTs)

The House received a progress report on the AMA's proposal to create a new category of bedside care giver called Registered Care Technologists (RCTs). The Board announced that one or more of similar programs would be evaluated and a pilot project would be implemented to demonstrate and evaluate the training of RCTs.

In a related action the House adopted an amended resolution proposed by the Reference Committee and the New York delegation that responded to testimony that the AMA should seek alternative proposals that will be less confrontational with our nursing partners.

The resolution reads:

- That the AMA continue to seek solutions to the problem of the shortage of bedside care givers, in addition to the Registered Care Technologists Program.
- That the American Medical Association recognizing the concerns of our partners in health care, the nursing profession,

work together with the American Nurses' Association and other nursing organizations to address the nursing shortage, and to continue to seek innovative ways to alleviate the acute shortage of bedside care providers, and that the Board of Trustees report to the House of Delegates at the Annual Meeting in 1989.

## Faculty Sexual Involvement with Medical Trainees

Sexual harassment and sexual exploitation between medical trainees and their faculty supervisors was the subject of a resolution submitted by the Resident Physicians Section.

The ethical issues raised by this conduct caused considerable debate including a personal account.

The House approved an amended resolution that calls on the AMA:

- to study the ethical issue raised by the existence of sexual harassment and sexual exploitation between medical trainees (medical students and residents) and their faculty supervisors, with particular attention to the effect of such relationships upon the quality of medical training, patient care, trainee evaluation, and the trainees' well-being; and
- to instruct its representatives to the Accreditation Council for Graduate Medical Education to encourage its Residency Review Committees to establish a mechanism to identify and eliminate instances of sexual harassment and for sexual exploitation in clinical training programs.

## Professional Liability

Professional liability and insurance continues to be a major issue before the House of Delegates.

The House received a report describing the work of AMA's Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability. The report discussed the continuing study

of a number of resolutions relating to expert medical witnesses.

In other actions the House adopted the policy calling on the AMA:

- to establish a policy that each physician should be able to maintain what he or she determines to be an appropriate amount of liability insurance except where otherwise required by state law; and
- to support the policy that physicians not be required to divulge the exact amount of their professional liability coverage as a condition of hospital medical staff privileges but should be allowed to provide verification that the minimum level of coverage required by the medical staff by-laws is in effect.

## Alcohol Use During Pregnancy

The House approved a resolution asking the AMA:

- to seek appropriate federal or state legislation to require that warning signs, stating that drinking alcoholic beverages during pregnancy can cause birth defects, be posted in a prominently visible location in all places where alcoholic beverages are sold.

## AMA Budget, Fiscal 1989

The House considered the 1989 plan and budget and commended the Board of Trustees, its Finance Committee, and the Executive Vice President for their prudent management of the Association's financial resources.

The budget includes operating revenues of \$187,440,000 and operating expenses of \$185,060,000, resulting in a favorable balance between revenues and expenses of \$2,380,000.

After incorporating a provision for income taxes of \$500,000, the anticipated revenue in excess of expense from normal operations is



\$1,880,000, which amounts to one percent to total operating expenses.

## **"Medically Unnecessary" Statements**

The House commended the Board of Trustees for its activities on this issue and adopted the following policy:

- That the American Medical Association continue to call for the repeal of the "medically unnecessary" provisions of section 9332(c) of the Omnibus Budget Reconciliation Act of 1986; and
- That until such time an appeal is achieved, the American Medical Association urge the Health Care Financing Administration to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service.

## **Nursing Homes**

The House adopted the following statement regarding quality of care and physicians reimbursement in the nursing home setting:

- That the American Medical Association and the federation work to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors, and express our commitment to quality care in the nursing home; and
- That the AMA work with the legislative and administrative bodies to ensure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
- That the AMA assist attending physicians and medical direc-

tors to develop quality assurance guidelines and methods appropriate to the nursing home setting.

## **Boxing as an Olympic Sport**

Reiterating the AMA's position to boxing, the House voted to:

- Communicate AMA's policy of opposition to boxing to the U.S. Olympic Committee; and
- Request the U.S. Olympic Committee to transmit this policy to the International Olympic Committee and ask that boxing be eliminated as an Olympic sport.

## **Southeastern Delegation**

Charles D. Hollis, Jr. is currently President of the Southeastern Delegation and is doing his usual excellent job. Georgia Delegation is proud of Charlie.

## **Resignation of Georgia Delegate to AMA**

Your Georgia Delegation to the AMA regrets the resignation of William W. Moore, Jr., M.D. of Atlanta as AMA Delegate. Dr. Moore has done his job well and will be sorely missed. Our best wishes and prayers go with Bill and Peggy.

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## **GEORGIA HEALTH NETWORK**

### **S. William Clark, Jr., M.D.**

**D**uring 1988, Georgia Health Network — as IPA — continued in its role as physician advocate with respect to medical-economic issues. Some issues were national in scope, others were statewide, and some affected only specific communities within Georgia.

In January 1988, GHN filed a Privacy Act/ Freedom of Information

Act administrative demand against HCFA for release of Medicare MAAC data to Georgia physicians. HCFA was attempting to force physicians to make their Medicare "participation decision" without the financial data upon which to make an informed decision. HCFA subsequently did release the MAAC data and created an "open window" in March during which physicians could opt in or out of the Medicare program for the balance of calendar 1988.

By year-end, it had become clear that another national issue was focused on Georgia, specifically on OB-Gyn's practicing in Savannah. Public and private remarks made at the AMA fall meeting by the Chief of the Antitrust Division of the U.S. Justice Department confirmed that medical antitrust is now a first priority issue with both the FTC and the Justice Department. He pointed out that the FTC and the Justice Department have recently launched investigations of physicians and dentists in other parts of the country and stated that criminal prosecutions of physicians under the antitrust laws may be forthcoming.

What has begun in 1987 as a limited FTC administrative investigation was transmogrified during 1988 into a Justice Department criminal investigation of virtually all OB-Gyn physicians in Chatham County. Early on, GHN helped coordinate legal representation of the physicians involved and assisted the Georgia Medical Society in responding to its own government subpoena for some five years worth of Society files and records.

In meetings with Justice Department officials, lawyers for GHN and the AMA argued that criminal prosecution is not the most effective way to achieve the government's apparent objectives and is otherwise inappropriate from both a legal and societal point of view. The investigation has continued however; a grand jury has been convened and is hearing testimony.



We continue to monitor the Savannah situation closely and maintain contact with both the AMA and the Georgia Medical Society. Each of the physicians involved, of course, is represented by his own individual counsel.

Shortly before the 1988 session of the Georgia General Assembly, GHN petitioned Insurance Commissioner Warren Evans to require, by regulation, that all third-party participation agreements contain certain minimum terms, for the protection of physicians and patients. The petition was endorsed by the MAG Third Party Relations Committee and asserted four principal points:

- First, all contracts should explicitly set forth the conditions upon which “risk withhold” money will be repaid to the participating physicians.
- Second, the insurance companies holding such “risk withhold” monies should be bound to the standards of care and candor applicable to trustees and other fiduciaries.
- Third, all contracts should provide a 90-day “free look” period during which the physician may review any proposed contract change and, if he rejects it, arrange other care for his patients who are covered under that contract.
- Finally, third parties should be required to re-publish their “provider list” when the composition of the lists changes by any appreciable amount.

When the General Assembly did convene, legislation was introduced to authorize and regulate PPO's in Georgia. As the bill moved through the legislative process certain language was removed which would have authorized individual physician capitation reimbursement schemes in PPO arrangements. In committee hearings, it was made clear that the General Assembly intended that physicians not

be subjected to capitation schemes, and the Insurance Commissioner stated that he would, by regulation, preclude such arrangements.

In later public hearings on his proposed regulations, the Commissioner came under heavy pressure from the insurance industry to permit physician capitation as a cost-saving mechanism. The Commissioner's final regulations do appear to prohibit capitation (albeit in somewhat ambiguous language), and they do include several of the other points urged by GHN.

Early in 1988, GHN initiated an in-house contract review service for physician members. To date seven different third-party contract proposals have been reviewed. In each case, the requesting physician has been provided with a detailed written analysis, in non-legal terms, that includes suggested negotiating strategies on specific issues that need to be modified. During the course of the year, we noticed that third-party contracts, for whatever reason, appear to be less predatory than in years past. Specifically, none of the contracts reviewed contained the “hold harmless” language that was common in earlier contract proposals. The contract review service is provided to GHN members at no charge.

GHN monitored and reported to its members on other important issues during 1988. The U.S. Department of Defense moved to establish a CHAMPUS discount PPO in Georgia among physician members of the Blue Cross/Blue Shield VIP network. The program has developed rather slowly and participation remains a decision for each individual physician.

HHS's administration of its “medically unnecessary” program during 1988 became so objectionable that litigation against HHS by GHN, MAG, or the AMA was discussed on several occasions. GHN maintained contact with AMA as it negotiated more reasonable administrative procedures with HHS

which seem to have alleviated many of the problems. We continue to monitor litigation pending in federal court in North Carolina challenging the constitutionality of the entire “medically unnecessary” program.

Also during 1988, GHN was involved in several purely local medical economic issues. The Rome Area Health Care Coalition was founded and moved to establish friendly relations with local physicians through GHN. Although the GHN bid to manage the Coalition's utilization management program was not selected, the atmosphere of trust and respect that has been created will ultimately benefit the physician community in the Floyd County area.

In Gainesville, GHN attorneys briefed Hall County physicians on plans by a local hospital to adopt a “Medical Staff Development Plan,” which could have produced a *de facto* closed staff. The hospital discontinued development of the plan, at least temporarily, after physicians asked questions about the plan and its long-term implications for the medical staff.

Finally, after almost three years of discussions and negotiations with the Association for Quality Health Care (AQHC), the Columbus-area business coalition, an agreement was reached under which GHN physician members will have equal access to the sizable group of patients covered by the AQHC member companies. Previously, many GHN physicians had access to these patients only on a “non-preferred” basis. The agreement puts GHN physicians on the same footing, in terms of both reimbursement and “preferred status,” as the members of two other local physician groups, Health Trust, Inc., and Physicians Group, Inc.

Physician advocacy, as described herein, has become and will continue to be the principal activity of GHN, which remains the only statewide entity that can represent



physicians across the entire spectrum of medical economic activity.

## REPORT OF THE AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

**Jan. W. Collins, President,  
A-MAG  
(Mrs. William C. Collins)**

**Theme for 1988-89:  
"Getting Our Act Together  
and Taking It  
On The Road"**

### Organization

**T**here are thirty-three county auxiliaries as follows: Baldwin, Bibb, Carroll-Haralson, Cobb, Colquitt, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk Chattooga, Franklin, Georgia Medical, Glynn, Gwinnett-Forsyth, Hall, Jackson-Banks, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Randolph-Stewart-Terrell, Richmond, South Georgia, Sumter, Thomas Area, Tift, Troup, Upson, Walker-Catoosa-Dade, Ware, Wayne, and Whitfield-Murray.

### Directed By: MAG Committee on the Auxiliary

William C. Collins, M.D., Chairman, Joseph P. Bailey, Jr., M.D., James A. Kaufmann, M.D., Jack F. Menendez, M.D., Joe L. Nettles, M.D., Jeffrey Nugent, M.D., Charles W. Walden, M.D.

### MAG Committees

Fourteen (14) auxiliaries serving on MAG committees.

### Membership

To date: March 31, 1989 — 2,549 members.

### Auxiliary Executive Board

The Executive Board of the Auxiliary to MAG is composed of ten (10) elected and two (2) appointed officers; all past state presidents; county presidents; and current chairman of standing and special committees and committee members.

### State Meetings

*Post Convention Executive Board Meeting*  
DeSoto Hilton, Savannah, Georgia, April 30, 1988

Special guests were: Mrs. Jean Hill, President-Elect, AMA Auxiliary; Mrs. Joan Millburn, President SMA; Dr. Jack F. Menendez, President, MAG; Dr. Joseph P. Bailey, Jr., President-Elect, MAG; Dr. Joe Nettles, nominated President-Elect, MAG; members of the MAG Committee on the Auxiliary. The programs for the coming year were introduced. Announcements of the Summer Executive Board Meeting Program were made. Program presented by Miss Courtenay Collins, singer, actress, and Julliard student.

*Summer Executive Board Meeting*  
Jekyll Island Club, Jekyll Island, Georgia, July 10-12, 1988

Adolescent Health Program speakers: Martin Moran, M.D., Key-note address; Ed Fowler, M.D., and Ms. Margo McKinley, Teen Sexuality; Martha Morrison, M.D., Drug and Alcohol Abuse; Diane Solursh, Ph.D., and Mrs. Betsy Fowler, Suicide/Emotional and Eating Disorders; Joy Maxey, M.D., and Mrs. Terri Hall, Child/Adolescent Abuse.

Workshops lead by auxiliaries in Membership, Adolescents & AIDS, producing a Health Fair, and Fundraisers. Osteoporosis workshop speakers were William C. Collins, M.D.; Thomas Marks, M.D., and Gary Sullivan, M.D. Other speakers were Joseph P. Bailey, Jr., M.D., President of MAG; and Joe L. Nettles, M.D.; President-Elect of MAG.

Liability Support Program: Panel of auxiliaries, Moderator, Paul Shanor; Mock Trial: Wallace Harrell, Attorney-At-law; William H. Pinson, Jr., Attorney-At-Law; William P. Franklin, Jr., Attorney-At-Law, and Dr. and Mrs. Roy Vandiver, Plaintiffs.

*Winter Executive Board Meeting*  
Wyndham Vinings Hotel, Atlanta, November 13-15, 1988

Speakers: Joseph P. Bailey, Jr., M.D., President, MAG. Legislative workshop produced by the A-MAG Legislative Team included the following speakers: Paul Shanor, MAG Legislative Counsel; Richard Greene, MAG Legal Counsel; Joe T. Wood, MAG Legislative Consultant; Steven Marlow, M.D., Ralph A. Tillman, M.D.; Mrs. June Bratcher, Texas Auxilian.

Mr. Franklin Garrett, Official Historian of the Atlanta Historical Society, spoke at the luncheon. Musical selections were presented by Ms. Lisa Browne, Music Faculty, Pace Academy, accompanied by Mrs. Jean Galloway.

Adolescent Health Program Speakers were Dana Banks and Gayanne Burns, Tennessee auxiliaries, Betsy Fowler, Dietary Consultant for Eating Disorders, Woodbridge Hospital; Marsha Wilkinson, Project Director, Department of Human Resources, Public Health Office, Carole Middlebrooks, Coordinator of Alcohol and Drug Education, University of Georgia.

*Medical Association of Georgia Leadership Conference*  
Ritz Carlton Hotel, Atlanta

*Annual Convention of the House of Delegates*  
Hyatt Ravana Hotel, Atlanta, May 3-5, 1989

Speakers: Mrs. Barbara Thibodeaux, President, Southern Medical Association Auxiliary; Joseph P. Bailey, Jr., M.D., President, MAG; Mrs. Frances P. Statham, internationally renowned author and a past state Auxiliary president.



## National Meetings

*AMA Auxiliary Annual Convention*  
Chicago, Illinois, June, 1988

Nine (9) delegates attended.

*AMA-A Leadership Confluence I*  
Chicago, Illinois, October, 1988

The State President, President-Elect and six (6) county presidents-elect attended.

MAG President and A-MAG President presented a seminar — "Team Efforts — Medical Societies and Auxiliaries"

*Southern Medical Association Auxiliary Annual Convention*  
New Orleans, Louisiana, November, 1988

Mrs. Barbara Thibodeaux of Marietta, Georgia installed as SMA-A President. The Georgia delegation hosted a reception in her honor.

*AMA-A Leadership Confluence II*  
Chicago, Illinois, February, 1989

The State President, Nominated President-Elect, and six (6) county presidents-elect attended. MAG President and A-MAG President presented a seminar "Team Efforts: Medical Societies and Auxiliaries."

## County Meetings

The A-MAG President visited the following county auxiliaries: Baldwin, Bibb, Carroll-Haralson, Cobb, Crawford W. Long, DeKalb, Dougherty, Floyd-Polk-Chattooga, Georgia Medical, Glynn, Gwinnett-Forsyth, Hall, Laurens, Medical Association of Atlanta, Muscogee, Newton-Rockdale, Ogeechee River, Peachbelt, Richmond, South Georgia, Sumter, Thomas Area, Tift, Walker-Catoosa-Dade, Ware and Whitfield-Murray.

The President-elect, the First Vice President, and the Area Vice Presidents traveled with the President at their convenience.

The President addressed the counties on the areas of Adolescent Health, Membership, Political Action, Legislation, AMA-ERF, Healthy

Lifestyles, Campaign of MAG, *How To Cope: The Surviving Spouse* booklet, GaMPAC, Leadership Training, teamwork between Medical societies and auxiliaries, William R. Dancy, M.D. Scholarship Fund, Medical Heritage, Motivation, and Public Relations.

## Publications

*Pulse Line* — four (4) issues mailed to all auxiliary members.

*Auxiliary Directory* — a copy mailed to each member.

*Annual Report* — Copies mailed to all Executive Board Members.

*Auxiliary Issue of the Journal of the MAG* — The April, 1989 *Journal to MAG* was devoted to auxiliary activities. Copies were mailed to each member of the Auxiliary Executive Board in addition to the members of MAG.

## Projects & Programs

### Adolescent Health

"It's Up To Youth" Teen Health Forum, University of Georgia, March 14, 1989. This Teen Health Forum, co-sponsored by MAG, A-MAG, and the University of Georgia was attended by 655 eighth, ninth and tenth graders and 106 high school teachers and guidance councilors. Two hundred and sixty-one (261) schools were contacted; fifty-five (55) schools participated. Speakers were: Joseph P. Bailey, Jr., M.D., President, MAG; William C. Collins, M.D., Orthopedic Surgeon; Reverend Pat Seymour, Episcopal Minister; Ray Goff, Head Football Coach, U.G.A.; Martin Moran, M.D. Pediatrician; John E. Fowler, M.D., Family Physician; Margo McKinley, R.N.; Peter M. Payne, M.D.; Gynecologist; Thomas L. Lyons, M.D., Obstetrician & Gynecologist; Carole Middlebrooks, Coordinator of Alcohol and Drug Abuse, U.G.A.; Jack F. Menendez, M.D., Surgeon and Oncologist, Immediate Past President, MAG; Heather Hays, Anchor Hospital; Joy Maxey, M.D., Pediatrician; Vernon Hall, Advisor, SCOAR Chapter, U.G.A.; Timothy C.

Knowles, Mental Health Assistant, Fulton County Emergency Mental Health Service; Barbara Nama, A.S.C.W.; Scott Snyder, M.D., Psychiatrist; W. Theron McLarty, Jr., M.D., Psychiatrist, Ridgeview Institute; Robert E. Dicks, M.D., Neurosurgeon; Lynn W. Dicks, Chairman, National Head & Spinal Cord Injury Prevention Program for Northeast Georgia; James Aberson, Spinal Cord Injuries Special Speaker; William B. Mulherin, M.D., Orthopedic Surgeon; Ron Elliott, U.G.A. Team Trainer; Frank Kelly, M.D., Orthopedic Surgeon; Chenaault Hailey, M.D., Dermatologist; Mrs. Marianne Broadbear, President, Success Image and Young Sophisticates; Mrs. Carol Grant, State Chairman, Georgia Junior Miss Scholarship Program; Ms. Dana Brown, 1987 Georgia Junior Miss; Ms. Diedre Ross, 1988 Cobb County Junior Miss; Ed Lewis, M.D., Dermatologist; Dick Ferguson, Owner Dick Ferguson's Men's Store; Reverend Jon Appleton, Minister of the First Baptist Church, Athens; Mark Hutto, M.D., Psychiatrist; Steven Lee, M.D., Psychiatrist, Medical Director of Charter Peachford Hospital; Mrs. Alice Asbell, Bibb Medical Auxiliary; Mrs. Joyce Johnson, Bibb Medical Auxiliary, and Mrs. Maureen Vandiver, AIDS Education facilitator, DeKalb Medical Society Auxiliary.

The aerobics session was led by Mrs. Toni Malcolm of Creative Conditioning. Role model speakers included Wayne Radloff, Falcon Football player; Wycliffe Loveless, U.G.A. football player; Kevin Brown, U.G.A. football player; Theresa Edwards, U.G.A., women's basketball player and gold Medalist; Aaron Chubb, U.G.A. football player; Mark Lipson, U.G.A. baseball player; Laura Wood, Drum Major, U.G.A. Red Coat Band.

Entertainment was provided by Frances Frazier, "Miss Georgia," 1988-89; U.G.A. "Derbies" Pep Band, and Alpha Delta Pi Sorority "Diamond Girls" Chorus.



"It's Up to Youth" forum was co-chaired by Mrs. Barbara Tippins and Mrs. Connie Menendez.

## *AIDS*

An educational program on AIDS was presented at the Summer Executive Board Workshop, as well as at the "It's Up To Youth Program." Many auxiliaries around the state have been trained as AIDS facilitators. They present programs in the schools and for community churches and civic organizations.

## *Child Abuse Prevention*

Approximately five (5) county auxiliaries continue to show the "It's OK To Tell" puppet show in the classroom. Child/Adolescent Abuse workshops were given at the Summer Executive Board Workshop and at "It's Up To Youth" forum in Athens.

## *Drug and Alcohol Abuse*

This year's emphasis has been on drug and alcohol abuse as it related to adolescents. Workshops were given at Summer and Winter Executive Board meetings and at "It's Up To Youth" forum.

## *Eating Disorders*

Recognizing that eating disorders is a growing concern with adolescent health, the A-MAG presented workshops in this field at the Summer and Winter Executive Board Meeting and at "It's Up To Youth" forum in Athens.

## *Healthy Lifestyles*

The Auxiliary to MAG continues to encourage county auxiliaries and medical societies to order and distribute MAG's Healthy Lifestyle brochures. In addition, the county auxiliaries are distributing the film *Scenarios*, developed by MAG's Public Relations Committee in connection with Healthy Lifestyles, to high schools throughout the state. This film "premiered" at the "It's Up To Youth" forum and a copy was given to each school participating.

## *International Health*

County Auxiliaries participate in International Health in a variety of ways — from collecting and sending medicine to countries where disaster has struck, to sending funds to aid relief programs, such as the "adopting a goat program" for Haiti.

## *Older Americans*

Several county auxiliaries have projects throughout the year to aid older Americans, from mall walks to blood pressure checks, vision screening, and distribution of medicine cards.

## *Safety*

**Seat Belts** — Many county auxiliaries sponsored seat belt projects this year. Each auxiliary examined the needs in its individual community and directed its focus accordingly.

Whitfield-Murray concentrated on a campaign to get seat belts put in school buses. Hall Auxiliary educated 250 — three, four and five-year olds on seat belt safety, distributing stickers, comic books and clicker toys. Their mascot "Mrs. Bucklebear" is in great demand, not only in Hall County, but throughout North Georgia.

**Safety City** and **Kids in Charge** are other safety projects adopted by county auxiliaries in teach safety to children.

## *Teen Sexuality*

The "You Can Say NO — Postponing Teenage Sexual Involvement" program continues to be used by county auxiliaries. Statewide workshops on postponing teenage sexual involvement were given at the Summer Executive Board Meeting and at "It's Up To Youth" forum in Athens.

## *Teen Suicide Prevention*

Many county auxiliaries have had speakers on Teen Suicide Prevention and have initiated projects in their own communities. Workshops on Teen Suicide Prevention

were given at the Summer Executive Board Meeting and at the "It's Up To Youth" forum in Athens.

## *The Surviving Spouse — How to Cope*

This is a continuing project whereby these booklets are available to aid the spouse of the physician in the settling of the estate and the selling of the practice following the death of the physician.

## *Tobacco Hazards Program*

Richmond County continues the program it initiated to teach children the dangers of tobacco. Other auxiliaries around the state are duplicating this program. Walker-Catoosa-Dade authored a project for pregnant women on the dangers of tobacco.

## **Legislative Programs**

### *Spouse Involvement Program*

This continues to be an active and integral part of MAG's legislative thrust. County auxiliaries visit the Capitol to meet with their legislators to discuss pending medical legislation.

### *Legislative Phone Bank*

The "Hot Line" phone bank operates every week day throughout the Session of the General Assembly. It is "manned" by 4 to 6 auxiliaries daily from surrounding counties. The purpose of the phone bank is to contact physicians from around the state encouraging them to contact their legislators on pending bills requiring immediate action.

In addition, each county auxiliary was requested to form its own "phone tree" so that medical legislation information could be distributed statewide in a matter of hours.

### *Key Contact Program*

This ongoing program matches the names of auxiliaries with those of legislators that they know and are willing to get to know for the pur-



pose of promoting medicine's needs in legislation.

## GaMPAC-AmPAC

One auxilian from each congressional district serves on the GaMPAC Board. The President of A-MAG serves on the Board as an ex-officio member, and also serves on the GaMPAC Bylaws Committee.

The President, in her county visits, urged auxiliaries and their spouses to join GaMPAC.

## Legislative Day at the Capitol

This year's theme was "Some Like It Hot." A legislative workshop by the same title was presented at the Winter Executive Board Meeting to educate participants about pertinent medical legislation.

The "Day At The Capitol" was attended by auxiliaries throughout the state. Legislative briefings were given on buses shuttling participants to the Capitol. During the morning, auxiliaries called out their legislators and discussed with them MAG's positions on pending legislation. Lunch at the Ritz-Carlton honored women legislators.

## Other Projects & Programs

### AMA-ERF

Efforts were accelerated this year in fund raising from AMA-ERF on the state and county level. AMA-ERF donations have hit a record high. State projects have included a highly successful silent auction, jewelry raffle and holiday sharing card. On the county level, many creative projects have been instigated to raise money for AMA-ERF from holiday sharing cards, to dinner dances, to wine tastings, to gift wrap sales.

### William R. Dancy, M.D. Student Loan Fund

This loan fund has been an ongoing Auxiliary project since 1930 to aid students in medical colleges in Georgia who are deemed to need

financial assistance to complete their medical training.

## Doctors' Day — March 30

All county auxiliaries throughout the state celebrate Doctors' Day. The various ways in which auxiliaries and the community honor their physicians is limitless: luncheons and programs are given for retired physicians and widows; physicians are recognized in church bulletins; red carnations are placed in church sanctuaries; patient's tray cards and red carnations are presented on March 30, receptions are planned for doctors; breakfasts are given to the house staff by hospitals; medical families donate blood to the Red Cross in honor of doctors. In addition, Mrs. Barbara Thibodeaux of Marietta, Georgia, President of the SMA Auxiliary, has urged that all physicians' spouses have a breast examination as a Doctors' Day project.

## Malpractice Support

County auxiliaries throughout the state have malpractice support groups and present programs on this subject to aid their members. A malpractice support panel was presented at the Summer Executive Board Meeting.

## Medical Heritage

One of this year's Auxiliary goals has been a special emphasis on Medical Heritage. A liaison was established with the Crawford W. Long Museum to urge auxiliaries and physicians to contribute and visit this medical museum. Each county has been encouraged to research its own medical history. Hall Auxiliary is actively participating in the redesigning and exhibiting of its medical history at the Green Street Museum in Gainesville.

At each state meeting, in Jekyll Island, in Vinings, and in Atlanta, a portion of the program has been devoted to medical history.

## The Medical Profession in Georgia 1733-1983 by Evelyn Gay

A-MAG and county auxiliaries continue to promote the sale of this medical history to benefit the William R. Dancy, M.D., Student Loan Fund.

## Membership

The Membership Committee of A-MAG has worked throughout the year to recruit and retain Auxiliary members. A workshop on membership was presented at the Summer Executive Board Meeting. The Membership Committee is presently working to reorganize two counties who have had auxiliaries in years past.

## Summary

This past summer, the AMA Auxiliary contacted Mrs. Jan Collins, A-MAG President and Dr. Joseph P. Bailey, Jr., MAG President, asking that they present a program at two National Leadership Confluences in Chicago. The program entitled *Team Efforts: Medical Societies and Auxiliaries*, detailed the ways in which MAG and A-MAG work together to further their common goals for medicine. Georgia was selected as the state in the entire nation that works most effectively as a team.

The Auxiliary to the MAG wholeheartedly thanks the Medical Association of Georgia and the entire MAG staff for the confidence that it has placed in the Auxiliary as a viable member of the MAG Team.

The Auxiliary to the Medical Association of Georgia is profoundly grateful for the tremendous support — moral, physical and financial — that MAG has provided so that its Auxiliary can work statewide for the advancement of health education for all Georgians and the betterment of the family of medicine.



### MAG MUTUAL INSURANCE COMPANY

**Charles D. Hollis, Jr., M.D.**

**O**ur commitment to our physician policyholders was demonstrated in 1988 by the many new and innovative programs we instituted in response to physician needs. We began the year by offering prior acts coverage. This option allows physicians to switch their coverage to MAG Mutual without purchasing expensive tail coverage from the current carrier. This new program, made possible by the company's increasing financial strength, was implemented February 1 in response to the needs of Georgia physicians.

Our rates have no profit factor built into them and are designed only to cover losses and the expenses of operating the company. This was demonstrated in March when the company declared a five percent refund of 1987 premiums for all policies which renewed on or after April 1. This refund resulted from better than expected 1987 results. The Board of Directors voted to return the difference to the policyholders. This is just one more way in which MAG Mutual represents the interests of Georgia physicians.

On May 1, MAG Mutual implemented its LEAD (Loss Excellence Appreciation Discount) program. This premium discount program recognizes and rewards the vast majority of our policyholders who have excellent loss experience. The size of the savings is based on the number of years a physician has been insured with MAG Mutual and the number or consecutive years he or she has not had a paid loss in excess of \$10,000. The savings increase each year upon renewal to a maximum of 10 percent as long as the physician remains loss free.

Also in May, the company began a program which offers policyholders who have been insured with MAG Mutual three or more years the opportunity to earn credit toward the purchase of their tail coverage at retirement. For each year after a physician reaches age 60, he/she will earn an annual credit of 20 percent toward the cost of the Reporting Endorsement at retirement. This enables a physician to retire any time between age 60 and 65 and pay a reduced tail coverage premium.

September 1 saw the implementation of the Anesthesia Premium Reduction Program. This innovative, voluntary loss prevention program was designed by a task force of the Georgia Society of Anesthesiologists to improve patient safety and decrease the chances of anesthesia claims. Participation in this program entitles the anesthesiologist to a 12 percent (up to \$3000) premium discount. A committee of the Georgia Obstetrical and Gynecological Society is likewise developing a voluntary loss prevention program to benefit Georgia obstetricians.

September 1 also saw a reduction in risk classification for ENTs which resulted in substantially lower premiums and surplus certificate requirements. This new class 4A could save our ENT policyholders as much as 23 percent a year. This reduction was made possible by improved loss data for ENTs.

On September 15, MAG Mutual began financing the purchase of surplus certificates. This makes it possible for new policyholders to spread the cost of purchasing surplus certificates over the policy period.

These many changes, revisions and improvements are examples of our commitment to Georgia physicians. We are dedicated to meeting your changing needs while continuing to provide the best quality service possible.

### ATTACHMENT

#### MAG Mutual is Different

- No settlement of claim without physician's written consent.
- Allows physicians to pre-pay tail coverage while still in practice in anticipation of early retirement.
- Earn 20 percent per year credit toward tail coverage beginning at age 60 when insured with MAG Mutual for 3 or more years.
- Free tail coverage at age 65 for those who have been with company more than 3 years.
- Option to purchase only the difference in tail coverage between classes.
- Numerous premium discounts including those for semi-retired, groups, new doctors, and loss prevention seminar attendance.
- Immediate reduction in premium for physicians age 65 or older for reduced classification (example, obstetrics to gynecology only) without having to buy tail coverage.
- Refund of premium (5 percent of 1987 premiums) when losses are found to be less than expected.
- LEAD — Loss Excellence Appreciation Discount — recognizing excellent loss experience with premium discounts.
- Geographical Rating for coverage in excess of 1 million dollars — 5 percent rate reduction for metro-Atlanta physicians and 15 percent rate reduction for non-metro physicians.
- Physician peer review to select as policyholders only those physicians approved by their colleagues.
- Physician claims committee to analyze medical information and advise staff and attorneys regarding appropriate direction of claims management and a commitment to contest every non-meritorious claim. Among major insurance carriers only MAG Mutual has such a committee.



## MAG Mutual Insurance Company Financial Results

	12/31/87	12/31/88	Year-to-Date 2/28/89
Written Premium	\$55 Mil	\$70 Mil	\$93 Mil
Policyholders	3,344	3,664	3,676
G & A Expense Ratio	7.7%	7.8%	7.7%
Policyholders' Surplus	\$10.7 Mil	\$15.3 Mil	\$16.6 Mil
Total Admitted Assets	\$111 Mil	\$148 Mil	\$166 Mil
Invested Assets	\$94 Mil	\$126 Mil	\$136 Mil
Rate of Return on Investments	8.2%	8.4%	8.4%
Total Claims Reported	2,395	2,860	2,992
Claims Closed	1,470	1,997	2,111
Claims Opened	958	902	850
Claims Closed With Indemnity Payment	184	268	290
Total Claim Payments Since Inception (Loss and LAE)	\$3.59 Mil	\$50.4 Mil	\$54.5 Mil

## Claims 1988 Year End Report

1. Files opened in 1988: 466	Total since inception: 2860
2. Files closed in 1988: 528	Total since inception: 1997
19 closed with indemnity only	( 4%)
61 closed with indemnity and LAE*	(12%)
287 closed with LAE only	(54%)
161 closed with no pay	(30%)
528	
3. Loss payments in 1988	\$10,254,435
LAE payments in 1988	<u>\$4,216,268</u>
	\$14,470,703
4. Number of claims presented to the Claims Committee: 83	
5. Lawsuits received in 1988: 127	
6. Number of trials in 1988: 23	Won: 16      Lost: 6
	(One hung jury settled prior to retrial)
Trial since inception: 77	Won: 60      Lost: 15
	(Two hung juries — 1 settled prior to retrial; 1 pending)
7. Percentage of cases won:	79% if 3 appeals are unsuccessful
	83% if all 3 appeals are successful

\*LAE — Loss Adjustment Expenses

- Tort Reform to accomplish legislative relief of the professional liability problem relief is already being realized in reduction of frequency of claims. Other major commercial carriers did not participate in the campaign to attain these reforms.
- Continuing efforts to improve the quality of medical care in Georgia through restrictive underwriting, insurance guidelines in high risk specialties, education, and premium discounts for voluntary participation in MAG Mutual's anesthesia program (a task force is currently working on a similar program for OBs).
- Active loss prevention programs, co-sponsored by MAG, for both physicians and medical assistants with incentives and premium discounts to participate.
- Intensive educational program, co-sponsored by MAG and MAG Mutual, to explain the new informed consent law and how to comply.
- Low operating expenses and no loading of rates for profits and dividends. Our expenses ratio is less than 1/3 that of our chief commercial competitor.

## ACCESS TO MEDICAL CARE COMMITTEE

**Julian Duttera, M.D.,  
Chairman**

**A**lthough the Committee has not officially met this year, the Chairman, individual Committee members and staff have been actively involved in three very important activities directly related to assessing access to medical care needs and developing ways to meet those needs.

### Assessing Physician Supply and Distribution

In 1986, the Composite State Board of Medical Examiners, at the request of the MAG and in conjunction to the Joint Board of Family Practice, and the Georgia Department of Human Resources, initiated the Georgia Physicians Survey. This survey is computed with each application for licenses renewal. This has made it possible to have accurate, current demographic data as to how many physicians are actively practicing in Georgia, their speciality and where they are.

A total of 8,975 physicians were found to be practicing in Georgia. The most striking finding of the survey was the indication of a substantial deficit of physicians in Georgia, i.e., 148 physicians per 100,000 population when compared to the national average of 192 physicians per 100,000 or to the GEMANAC ideal of 200 physicians per 100,000 as a goal set for 1990. A recent study by Swartz, et al., suggests that GEMANAC prediction of a massive physician surplus will not occur and that, in fact, there will be a deficit of physicians by the year 2000.

Trends in physician supply are not easy to determine. It is very difficult for individuals, organizations,

and associations to agree on the most appropriate method for determining physician supply. However, if the physician population continues to grow, (as evidenced in the 1978-1985 period), we estimate that more than 400 physicians will be added each year to Georgia's physician supply. Thus, by 1990, we would add 1,600 new physicians while losing 1,025 due to retirement. This computation results in a net gain of 575 physicians. Due to the expected population growth, however, the 1990 physician to population ratio would remain unchanged from 1986 — 148.1/100,000 population.

In the year 2000, the situation is projected to be quite similar. By 2000, we expect to add 5,600 new physicians while losing 2,651 due to retirement — a net gain of 2,949 physicians. The resulting physician to population ratio of 160/100,000 is still well below the 1990 GMENAC standard of 191.4/100,000.

### Maldistribution

A more critical and certainly more urgent issue however, is the problem of maldistribution. With regard to the total numbers of physicians, this fact is not new. However, for the first time, in 1986, major maldistribution trends are emerging among primary care providers.

Sixty-eight percent of all physicians are located in 9 counties which collectively comprise 44% of the states' population. Of all physicians located in counties exceeding 20,000 population, only 13% are Family Practitioners. To compare, this specialty represents 57.2% of all physicians practicing in counties with less than 20,000 residents.

Only a few counties were without a family practitioner. The remaining primary care physicians (obstetrics/gynecology, pediatrics, internal medicine, and general surgery) showed severe maldistribution. Many counties had none of those specialists, with over half the counties without an obstetrician/

gynecologist or a pediatrician. Based on the 1986 survey, it is evident that Georgia faces a critical problem with the distribution of physicians, especially in rural areas of the state. The 1988 data is currently being evaluated to determine if these trends are continuing.

### Physician Acceptance of Specific Patients

An issue that is of continuing concern to the medical and public health communities is physician acceptance of Medicaid, Medicare, and obstetric patients. Of responding physicians, 71.2% accept Medicaid patients and 83.8% accept Medicare. Among the physicians participating in Medicaid and Medicare, there is great variation by specialty. Geographically, acceptance of these patients varies a great deal, also, a larger percentage of doctors accept Medicaid and/or Medicare in the more rural areas.

### Quality of Life

To improve Georgia's physician supply and maldistribution problems, we must begin to improve the overall quality of life in this state. Clearly, education, socioeconomic status, health status, and health access are all factors which relate to quality of life. In most of Georgia's rural areas, many of these factors show a poor level of attainment. High unemployment rates, a high percentage of high school drop outs, low educational attainment, high numbers of families living below the poverty level, high infant mortality, high death rates from strokes, low physician-to-population ratios, and poor accessibility to healthcare characterize the overall poor quality of life in rural Georgia.

Notably, the southwest and the central sections of the state have major areas where poor quality of life is evident. These areas also correlate quite well to areas of low physician rates. It is the quality-of-life which must be addressed if we ex-



pect to improve the supply and distribution of physicians in Georgia. We must provide a quality of life which is attractive to physicians and to all citizens of the state; thus, in time, we will begin to improve our social, economic, education, and health problems. The key to the future of improved health care in Georgia is improving the quality of life for her citizenry.

### Medical Fair

We are now starting our thirteenth year as a major sponsor of the Medical Fair. To date, 165 physicians have been placed in rural Georgia communities as a result of this program. The principal coordinator is the State Medical Education Board. It now has 16 additional sponsors.

Space available usually results in limiting participation to 40 communities, with an average of 110 residents each year for the last 5 years. Increased efficiency in community recruitment and resident preparation is apparent each year.

The 1989 Medical Fair will be held at the Atlanta Airport Marriott, October 13-14, 1989.

### Legislation

The 1989 Georgia General Assembly passed the "Physicians for Rural Areas Assistance Act" designed to increase the number of physicians in physician underserved rural areas of Georgia by making loans to young physicians who recently completed their medical education and allowing such loans to be repaid by such physicians agreeing to practice medicine in such rural areas. This program will be administered by the State Medical Education Board. Note that this law allows loans to establish practice in rural areas vis-à-vis scholarship loans for medical education. The adopted state budget included \$50,000 for this program. The SMEB expects to apply for additional funding through available federal grant funds.

Two other legislative activities have the potential for impacting on the accessibility of medical care throughout the state. Senate Resolution 70 and House Resolution 162 create a widely-representative "Access to Health Care Commission" to do a comprehensive study of the problem of access to health care for all Georgians. (Preliminary findings and recommendations are to be presented December, 1989, and a final report submitted December, 1990.) The MAG is named as one of the participating health groups.

In House Resolution 31, a Study Committee was created, "The Joint Health Care Personnel Supply and Planning Study Committee," to collect all the existing data on the supply and demand of personnel, available educational opportunities, and the trend in health care, analyze it, and formulate recommendations for actions. (Their report is due December, 1989.) Results of these activities will be reported as they become known.

## COMMITTEE ON THE AUXILIARY

**William C. Collins, M.D.,  
Chairman**

**C**ommittee members were as follows: William C. Collins, M.D., Chairman, Joseph P. Bailey, M.D., James A. Kaufmann, M.D., Jack F. Menendez, M.D., Joe L. Nettles, M.D., Jeffrey Nugent, M.D., and Charles W. Walden, M.D.

The Committee on the Auxiliary held the first meeting on April 8, 1988, in Atlanta for the purpose of reviewing the Auxiliary's proposed plans and approving the proposed budget. The Auxiliary calendar for 1988-1989 was announced. In addition to Committee members who attended, staff personnel included Mr. and Mrs. Paul Shanor, Mr. Scott Mall, Mr. and Mrs. Gary Marsh, Mr.

Hoyt Torras, Dr. and Mrs. Steve Davis, Mr. Mike Fowler, and Mr. and Mrs. Richard Greene.

The second meeting of the Committee was at the Post Convention Executive Board Meeting and luncheon of the Auxiliary, April 30, 1988, in Savannah. The Committee members were all present. The Chairman introduced the members of the Committee to the Auxiliary Executive Board. At this time, the Committee heard reports from the Auxiliary Committee Chairmen projecting their plans for the coming year. Announcements were made concerning the date, location, and program for the Summer Executive Board Meeting.

The third meeting of the Committee will be held in Atlanta at the Annual Convention of the House of Delegates of MAG, May 5, 1989.

*Auxiliary Programs and Projects* — Refer to the report of the President of the Auxiliary for a complete review of Auxiliary Programs and Projects for 1988-89.

## CANCER COMMITTEE

**LaMar McGinnis, M.D.,  
Chairman**

**T**here have been no specific issues presented which required review of the whole Committee; however, it has not been an inactive year.

**Georgia Division, American Cancer Society**

Your Chairman, individual Committee members and staff have participated in various committees of the Georgia Division of the American Cancer Society to assist in the development of its Long Range Strategies Plan. This plan is directed toward reducing the impact



of cancer through volunteer involvement in programs of public and professional education, delivery of services to cancer patients and their advocacy and supporting cancer research. The Committee will recommend appropriate MAG involvement as the different issues are addressed more specifically.

### **Mandatory Reporting of Cancer Incidence**

At its March 1989 meeting, the Board of Directors of the Georgia Department of Human Resources approved the request of The Division of Public Health to change the list of notifiable diseases to require that all new cases of cancer be reported to the state cancer registry on a yearly basis.

Cancer is the second leading cause of death in Georgia and in the United States. At the present time cancer is reported voluntarily to the state cancer registry; it is estimated that only 40-45 percent of all new cases are reported. Without complete statewide reporting this data cannot be utilized to conduct epidemiological studies in areas where there is suspected high incidence; this data cannot be utilized for the planning and evaluation of this State's Cancer Control Program. Recently a high incidence of leukemia was reported in the Dalton area with suggestions that it was associated with the carpet mills. A more thorough study could only be done by going to the hospitals and the laboratories to collect cancer incidence data. When planning for hazardous waste sites or nuclear power plants there is a need to know what is happening in an area before and after the hazardous dump or nuclear plant is built. There is no way to do that now. Thirty-seven other states already have mandatory reporting of cancer.

As you are aware, Georgia has had voluntary reporting of cancer incidence data by hospital cancer registries since 1965. Thirty-one hospitals with cancer registries cur-

rently participate in the program. It is estimated that an additional seven (7) hospitals have cancer registries and are not presently participating.

There are 108 pathology laboratories; 38 of the laboratories are in hospitals with cancer registries; these laboratories would not be required to report. There are 70 laboratories which would be required to report. Individual physicians will not be required to report separately.

The proposed laboratory reporting form was field tested with seven (7) laboratories, including small, medium, and large laboratories. One hundred percent of these laboratories felt a reporting form was necessary. Sixty-seven percent felt the reporting requirements could be easily performed prospectively. Eight-three percent felt the pathology laboratory should be designated reporter.

The DHR will be contacting those involved with more detail in the near future. It is expected that the program will be implemented by June 1, 1989.

### **Oncology Problems**

Recently, a letter from B. J. Kennedy, M.D., Chairman, Cancer Caucus, AMA House of Delegates, requesting Committee consideration of Oncology problems which should be brought to the attention of the AMA, was circulated to Committee members.

The Georgia Division of the American Cancer Society reports the following are concerns voiced by the membership of the Georgia Society of Clinical Oncology as well as the Breast Cancer Detection Awareness Committee:

1. Third party payer issues for treatment:

—Payment for outpatient chemotherapy and approval for inpatient costs for supportive therapy for chemotherapy administration. This includes the hassle of precertification.

—Coverage for interferon for use in cancers for which interferon is not specifically indicated.

—Coverage for autologous bone marrow transplantation.

2. Insurance coverage:

—Coverage for screening procedures such as mammography and pap smears.

—Issue of insurability for cancer patients in general.

3. Certification:

—Certification of mammography providers by the American College of Radiology as in many states there is no agency which insures that providers meet appropriate standards.

Another member expressed concern that there are still many females over the age of 50 who have not had a mammogram. Furthermore, a mammogram has not been requested by their primary care physician who sees them on regular basis. This is a critical point of education of primary care physicians and patients, before we can hope to see a change in cancer death rates from carcinoma of the breast in the next 10-15 years. Only through early detection will this be possible.

The Committee will meet in the near future to discuss these issues and make specific action recommendations to either the MAG Executive Committee or Board of Directors.

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## **CONTINUING MEDICAL EDUCATION COMMITTEE**

**George W. Shannon, M.D.,  
Chairman**

**T**hrough its work this past year, our Committee continues to maintain what we consider to be a



record of efficient service in promoting continuing medical education across the state.

## Accreditation

Our principal ongoing task remains advising and accrediting Georgia organizations and institutions which provide continuing medical education. (Accredited status allows the CME provider to authorize Category 1 AMA credit for appropriate educational activities.) In 1988 we conducted the initial accreditation survey of one hospital and resurveyed nine more hospitals or specialty societies, extending their period of accreditation according to their ability to meet the ACCME *Essentials* for Category 1 continuing medical education.

As of this writing, sixteen specialty societies or voluntary health agencies and twenty-three hospitals are accredited for CME by the MAG. These 39 providers are:

- American Academy of Pediatrics — Georgia Chapter
- American Cancer Society — Georgia Division
- American Heart Association — Georgia Affiliate
- Athens Regional Medical Center
- Atlanta Society of Pathologists
- Augusta Obstetrical & Gynecological Society
- DeKalb General Hospital
- Georgia Academy of Family Physicians
- Georgia Academy of Family Physicians Educational Foundation
- Georgia Baptist Medical Center
- Georgia Gastroenterologic Society
- Georgia Orthopaedic Society
- Georgia Psychiatric Physicians Association
- Georgia Radiological Society
- Georgia Rheumatism Society
- Georgia Society of Anesthesiologists
- Georgia Society of Ophthalmology
- Georgia Surgical Society
- Glynn-Brunswick Memorial Hospital
- Greater Atlanta Otolaryngology — Head & Neck Surgery Society

- John D. Archbold Memorial Hospital
- Kennestone Hospital
- The Medical Center
- Medical Center of Central Georgia
- Memorial Medical Center
- Metropolitan Hospital
- Northeast Georgia Medical Center
- Northside Hospital
- Phoebe Putney Memorial Hospital
- Piedmont Hospital
- Ridgeview Institute
- Scottish Rite Hospital
- South Fulton Hospital
- South Georgia Medical Center
- St. Joseph's Hospital
- Sumter Regional Hospital
- University Hospital
- VA Medical Center (Dublin)
- West Paces Ferry Hospital

During the past year, Committee members and staff have also held consultations with several institutions expressing interest in becoming accredited. We perceive that some of this interest reflects recent state legislative activity regarding an annual minimum of CME, mandated by the state for relicensure.

## Mandatory CME — MAG Activity, 1988-89

Last year's House of Delegates voted to 1) oppose the immediate drafting of a bill mandating continuing medical education for physician relicensure, but also, to 2) empower the MAG Committee on CME to recommend appropriate MAG action in the event of legislative activity favoring mandatory CME.

Last fall MAG became aware that some form of mandatory CME bill would probably pass the 1989 General Assembly. Furthermore, the Georgia Academy of Family Physicians voted to introduce a bill mandating CME. Given the latitude expressed in the second House action (above), last September 8 MAG's Council of Legislation voted unanimously for the MAG CME Committee to work with the GAFFP on a bill for the Academy to introduce to the 1989 Georgia General Assembly. The MAG Board of Directors ap-

proved this recommendation last September 17.

As thus directed, our Committee appointed a Subcommittee on Mandatory Continuing Medical Education to research the levels of mandatory CME in other states and to recommend guidelines for the drafting of a GAFFP bill. Chaired by William E. Silver, M.D., of Atlanta, with Hillary R. Newland, M.D. of Athens and Robert C. Fore, Ed.D. of Macon as members, the Subcommittee exhaustively studied mandatory CME across the nation and presented these findings:

## Mandatory CME Across the U.S. — A Status Report

Presently twenty-two states plus Puerto Rico require some minimum level of continuing medical education for physician relicensure.

a) The number of hours mandated by the several states varies from a low of 15 hours per year (Wisconsin) to 50 hours per year (nine states). The average minimum mandated by all twenty-three governments is about 31.3 hours per year.

b) Most states do not specify that these hours should be in AMA Category 1 credit, although a number of states require that some hours be in AMA Category 1 or equivalent credit. Equivalency usually extends to the credit issued by a national specialty society (AAFP, ACOG, AANS, ACEP) or American Osteopathic Association.

c) Most states appear to link their requirements to the medical licensure period, which usually varies between two and three years. Several states call for a minimum of CME to be earned *each* year.

d) In reporting their CME earned, physicians in a number of states must submit some formal documentation: a) a current AMA Physician's Recognition Award, b) an equivalent certificate issued by a national specialty, or c) a current recertification by a national, rec-



ognized specialty board. Several states allow physicians simply to sign a statement that he/she has met the CME requirement.

e) It seems that many states verify their physicians' CME participation by random sample audit. California requires physicians to retain records of their CME participation for four years, i.e., the two previous licensure periods.

f) From our examination, only one government, Puerto Rico, specifies that a certain percentage of the CME earned be in the physician's specialty. In two states risk management is required (5 hours in Florida, 10 in Massachusetts). Further, Massachusetts requires that one hour per year be in the physician's study of the state licensing board's current rules and regulations.

g) We saw little legislative language specifying the physician's penalty for failing to meet the required CME minimum. California states merely that failure to comply with audit requirements will result in delay or possible denial of the physician's license renewal. Alaska adds that its medical licensing board may grant an extension, and that it will take each physician's case on an individual basis.

\* \* \* \*

## **Mandatory CME: Our Guidelines**

Based on these findings, our Subcommittee proposed the following seven guidelines for MAG action on mandatory CME. Our full CME committee voted unanimously to approve them last December 14.

1. A minimum of 50 hours of continuing medical education activities to be completed by the physician during the two-year licensing period.

2. Forty of these hours must be in American Medical Association Category 1 credit, or in equivalent formal learning categories established by national specialty societies, or by the American Osteopathic Association. Activities of CME

appropriate for compliance with this requirement should be defined as lectures or conferences, audiotapes or video/learning materials, home study or correspondence courses, etc., which relate to the clinical practice of medicine and which are approved for credit by an organization or institution accredited as a provider of CME by the Accreditation Council for Continuing Medical Education, American Osteopathic Association, or a state medical association.

3. The physician should report his/her participation in CME by signature on the appropriate form issued by the Georgia Composite State Board of Medical Examiners, at the time of medical licensure renewal.

4. Verification of physicians' CME participation should be by random audit conducted by the Composite State Board. Physicians should retain documentation of CME credit earned for the licensure period in question, plus the previous period (i.e., for four years). Such documentation may include a current American Medical Association Physician's Recognition Award or similar certificate issued by a national specialty society, or evidence of current recertification by a national medical examining board.

5. Physicians seeking initial licensure should be required to take a course approved by the Composite State Board on Georgia's Medical Practice Act, prescribing and dispensing regulations, and risk management topics. Otherwise, the requirement for CME will apply only to those physicians seeking relicensure. (Resident physicians licensed during their postgraduate training, for instance, are therefore exempt.)

6. The Board may issue exemptions to physicians entering fellowships, new specialty residencies, etc. In all instances of physicians' non-compliance with the mandated minimum, the Board should have the authority to grant extensions or exceptions, as well as to decide

upon appropriate disciplinary action in case of non-compliance, on an individual case basis.

7. Implementation of the new law, assuming passage in the 1989 session, should begin January 1, 1990. Thus the first series of physician reporting would be with the licensure renewals issued in 1992.

\* \* \* \*

## **Mandatory CME: How It Went Down During the Session**

We communicated the above seven guidelines to the Georgia Academy of Family Physicians, and received its approval for all of them. Staff accordingly began drafting a GAFF CME bill.

We also conveyed these guidelines to the Composite State Board of Medical Examiners on December 8, but were told that the Board would likely introduce its own CME bill into the Session.

There were, in the end, *three* mandatory CME bills introduced in the Georgia General Assembly:

*HB 702* (The "GAFF bill") introduced by Rep. George Green, a family physician, at the request of the Georgia Academy of Family Physicians. The original version included our Committee's major points — not less than 30 hours, Category 1 credit, courses by accredited providers, etc. This passed the House on February 21. The Senate Human Resources Committee, which then got the House bill, kept the requirement of 30 hours biennially, but deleted the language about Category 1 or equivalent credit categories, and also about accredited providers. The Senate Committee passed its substitute Feb. 21.

Then Senator Beverly Engram of Newnan amended the bill, increasing the minimum from 30 to 40 hours per two years. In a surprise development, another Senator added an amendment which would require all physicians to accept Medicare and Medicaid patients as a condition of licensure. (What's



this got to do with CME?!) This bill passed the Senate on March 1. Rep. Green, the original sponsor, said that this amended Senate bill wasn't acceptable. The entire bill was therefore killed for this session.

**HB 798** (the "Board bill" — introduced by Rep. Buddy Childers of Rome, and others, the bill also called for 30 hours' CME as a condition of license renewal, but said little else, as the Board was given authority to pass rules and regs needed for implementation. HB 798 was still in the House Health & Ecology Committee at the end of the Session.

**SB 94** — introduced by Senator Engram. MAG opposed this because of its language that would revoke a physician's license if he or she failed to get at least 30 hours' CME in two years. This bill also died in Committee.

Outlook for next year is that the GAFFP bill will be considered again. Mandatory CME may yet come to Georgia.

As Chairman, I am indebted to the membership of my Committee — an impressive group of energetic physicians committed to ensuring the Medical Association of Georgia an influential role in continuing medical education. They are:

William C. Allsbrook, M.D.; John R. Broshears, M.D.; John L. Davis, III, M.D.; Joseph M. DeGross, M.D.; David Epstein, M.D.; John A. Hudson, M.D.; James S. Maughon, M.D.; Victor A. Moore, M.D.; Hillary R. Newland, M.D.; Neil G. Perkinson, M.D.; Alan Plummer, M.D.; Carl L. Rosengart, M.D.; Robert C. Schlant, M.D.; William E. Silver, M.D.; Barry D. Silverman, M.D.; Rodney L. Smith, M.D.; Roland S. Summers, M.D.; Charles R. Underwood, M.D.; William H. Whaley, M.D.

## EMERGENCY MEDICAL SERVICES

**Rodger W. Chapman, M.D., Chairman**

**A**lthough no formal meetings of the Emergency Medical Services Committee were held during 1988-89, the Committee and I, as Chairman, continued our consultation and liaison with state and federal agencies to improve emergency health services delivery in Georgia.

During the year, the Committee, through the MAG's legislative activities, gave support to Senate Bill 320 which passed both houses and is now on the Governor's desk for his signature. The law more forcefully asserts the medical control of the Emergency Medical Service System through appointment of a district medical director and ambulance service medical director.

Also during the year, the Committee continued its discussions with the Department of Human Resources concerning the need for a state-coordinated medical disaster plan. The Committee has been asked to serve as a project advisor with the Georgia DHR to a Center for Disease Control assessment team who will look at at least one region's present capability in handling a major disaster. The plan will give special consideration to how the private medical community can coordinate with and augment the state's present emergency services system.

## COMMITTEE ON IMPAIRED PHYSICIANS

**Edward J. Waits, M.D., Chairman**

**T**he Committee met on four occasions during the calendar year, approximately every three months. The Committee functioned primarily in the following areas:

- 1) Identification and verification of impaired physicians.
- 2) Intervention.
- 3) Evaluation of various forms of treatment and/or treatment centers.
- 4) Re-entry and monitoring of physicians previously treated.
- 5) Medical auxiliary activities and projects.
- 6) Legislative activities.
- 7) Education.
- 8) Selection and implementation of a Medical Director for the Impaired Physicians Program.

In each of these areas, the Committee has functioned productively. We continue to evaluate ways and means of identifying and verifying impairment among health professionals within the Medical Association and the medical communities throughout the state. Our committee members assume the posture of advocacy for these physicians.

In the field of intervention, we supply members of our Committee to the local hospitals and communities to set up intervention teams utilizing proven, effective methods for intervention of impaired physicians.

In evaluating various modalities and forms of treatment at treatment centers, our Committee has worked with the Composite State Board of Medical Examiners and its Medical Director in setting up standards for appropriate treatment.

In the area of re-entry and monitoring, we have studied and approved a "relapse contract" which is now being used by several hospitals throughout the state and is apparently effective in reducing the incidence of relapse on returning physicians and also reducing the risk of litigation for the institutions involved.

We continue to work with the auxiliary in setting up and in insti-



tuting workshops aimed at studying the effects of physician impairment on the medical marriage and the physician's family. There continues to be much interest in this field among auxiliaries. The auxiliaries of several medical societies have raised funds which are donated to assist impaired physicians in attending the annual Caduceus Club Retreat as part of their recovery process before returning to practice.

In legislative activities, we are attempting to study ways and means of instituting a surcharge on the licensing fee to help underwrite the expenses of our program, especially that of hiring and funding a Medical Director.

In the field of education, we continued to offer talks and video tapes to be used at various county society meetings and/or auxiliary meetings.

Lastly, our continued search for an appropriate candidate for the Medical Directorship of our program and the refinement of the job description for this post is a major activity of our Committee.

## MATERNAL AND INFANT HEALTH COMMITTEE

**Luella Klein, M.D.,  
Chairman**

**T**he activities of the Maternal and Infant Health Committee this year were directed primarily toward identification and alleviation of problems associated with the delivery of care through the Georgia Regional Perinatal System.

Two meetings were held with representatives of the participating Regional Tertiary Centers, the Department of Medical Assistance

(Medicaid), the Public Health Department, the Maternal and Infant Health Council, and the Georgia Hospital Association. Representatives of the Department of Family and Children Services were unable to attend.

Problems are myriad and cross the total spectrum of existence. The committee limited its consideration to those related to the major problems contributing to the increasing loss of money incurred by the tertiary centers in their neonatal intensive care units. The problem is so acute that at least two facilities are on the verge of withdrawing from the system which could, and indeed most likely would, destroy the regionalization of perinatal care in Georgia.

### I. PROBLEMS

#### A. NEONATAL

—Shortage of neonatal beds available to Medicaid and non-pay patients.

—Skimming: Physicians send private-pay patients to their hospitals — no-pay to regional centers.

—Many hospitals which have the necessary facilities and manpower, do not take Medicaid/no-pay patients and do not accept return transports of infants they have transferred to the regional system for perinatal care. (The regional system requires referring hospitals to accept the infant back for growing nursery care if it no longer requires tertiary nursing care.)

—Hospitals lose money on Medicaid neonatal tertiary nursery admissions. Increased eligibility of infants January 1, 1989 will expand this loss.

—Nursery costs are increasing due to increased technology, smaller infants, and longer stay, e.g., the average LOS has tripled in the last five years.

—Medicaid payment of hospitals by a flat rate makes neonatal nursery big loser — e.g., there may

be usual charges of \$30,000 to \$40,000 with payments of \$2,000 or \$3,000.

—Hospital cap on Medicaid penalizes hospital.

—State of Georgia prenatal and postnatal care system pays more for nursery care than Medicaid, per patient.

—Funds for administration of regional centers have increased very little in the last decade.

—Transportation is also becoming a problem in some areas.

### B. OBSTETRICS

—Regional centers can't geographically serve entire state, particularly in the southern part of the state. The obstetric component is not as well organized as the neonatal.

—They share the problem created by physicians sending paying patients to other facilities and no-pay patients to the regional centers.

—Reproductive/illiteracy; family planning funding decreased. There is no consistent effort to assist the people who are more likely to have high-risk pregnancies and babies in better planning their pregnancies. Title X funds are being reduced for family planning.

—Women eligible for Medicaid do not apply or certification is too complicated. Clientele difficult to reach/certify/register/comply. Inability to register early in the pregnancy keeps private physicians from accepting them as patients.

—Many physicians discontinue seeing patients if their bill is not paid by the 7th month. This frequently results in patients delivering in regional centers even if their is no problem with the pregnancy.

—Malpractice concerns are a major problem, particularly as they relate to the medically indigent.

—Need for increased resources to deal with genetic services.



## C. GENERAL

- Lack of a formal regionalized system with specific areas of responsibility.
- Lack of communication system(s) to allow rapid transfer of data relating to care of patients — either specific patient information or medical information relating to specific conditions.
- Manpower — Three types of problems appear to be relevant:
  1. Actual shortage, e.g., nurses;
  2. Rural areas which will never support the availability of local medical care;
  3. Available facilities and physicians that do not accept no-pay or Medicaid-pay patients.
- Need to distribute cost of care of the medically indigent on a more equitable basis.

## II. DMA/MEDICAID IMPROVEMENT (already being implemented)

- Increased obstetric payment rate for physicians.
- Some increased payment for pediatricians/neonatologists.
- Fifty disproportionate share hospitals have increased Medicaid reimbursement rates.
- January 1, for disproportionate share hospitals, obstetrics, and nursery care to age 1 will not participate in the Medicaid cap.
- More patients eligible for Medicaid.
- SOBRA expansion (Federal law raising eligibility to 100% poverty level) on January 1, 1989, applies to Medicaid not AFDC welfare, simplifies applications.
- Medicaid considers pregnant women as two (2) for calculation of poverty level.
- Certification will be for duration of pregnancy plus 60 days.
- DFCS more case workers 1989.
- Hospital appeals process available for different case mix; increased severity.
- Restructured reimbursement for Medicaid family planning 1989.
- Someone has said that until there

is a crisis created by babies and pregnant women not receiving medical care, nothing will be done about these problems. Babies are being delivered and medical care is being arranged — sometimes by sending patients out of state — but the bottom line is here NOW. The funding of the regional centers is totally inadequate. Eggleston Hospital which accepts 95% of the “out born” babies from the northern part of the state and Crawford Long Hospital which accept 90% of the maternal transfers, lost in excess of a million dollars on these programs last year. This is an intolerable situation. If these two hospitals drop out of the program, the rest of the system will collapse. Then there *will*

be mothers and babies who will not receive appropriate medical care. We cannot allow this to happen.

Efforts were made to advocate for additional funds from Medicaid and the Governor. Voluntary assistance in eligibility certification was offered to the Department of Family and Children's Services. In the 1989-90 Georgia General Assembly, the MAG's total tort reform package is directed toward obstetrical issues. The proposed bill will carry over to 1990. The committee will continue to work with other agencies to resolve these problems.

The following statistical data was provided by the Georgia Department of Human Resources, Vital Statistical Department.

	NUMBER			RATE		
	Total	White	Black	Total	White	Black
LIVE BIRTHS	102486	66201	34903	16.4	14.5	20.7
Age of Mother						
10-14	504	96	406	1.9	0.5	4.8
15-17	6549	3066	3463	37.8	26.2	61.5
UNWED MOTHER BIRTH RATE	28732	7557	21072	19.1	7.0	49.3
Age of Mother						
10-14	469	65	403	1.8	0.4	4.7
15-17	4657	1315	3335	26.9	11.3	59.2
Birth Weight*						
<1500 GM	1647	737	903	1.6	1.1	2.6
1500-2499 GM	6805	3356	3376	6.6	5.1	9.7
OUT OF HOSPITAL BIRTHS*	660	333	312	0.6	0.5	0.9
SPONTANEOUS ABORTION RATE	6845	4418	2351	4.5	4.1	5.5
Age of Mother						
10-14	34	9	25	0.1	0.1	0.3
15-17	345	194	150	2.0	1.7	2.7
INDUCED TERMINATION RATE	33509	18488	14080	22.2	17.1	33.0
Age of Recipient						
10-14	364	126	235	1.4	0.7	2.8
15-17	3486	2028	1414	20.1	17.4	25.1
TOTAL DEATHS	50167	36156	13900	8.0	7.9	8.3
Lifestages**						
Infancy (<1)	1306	678	620	12.7	10.2	17.8
Neonatal	866	465	398	8.4	7.0	11.4
Post-Neonatal	440	213	222	4.3	3.2	6.4

\* Rate per 100 live births

\*\* Rate per 100,000 population

All others — rate per 1,000 female population

### MEDICAL ASPECTS OF SPORTS COMMITTEE

**Letha Hunter-Griffin, M.D.**

**T**he 1988 *Medical Aspects of Sports Newsletter* was distributed to coaches throughout the state of Georgia. Topics included: Ankle Sprains: Prevention; Internal Injuries in Sports Medicine; Injuries to the Elbow in Sports; Anterior Cruciate Injuries in Athletes; Fluid and Electrolyte Problems in High School Athletes; Strength Training in Children: Questions Coaches Ask Most Often; Tennis Elbow; and The Use of Knee Braces. In addition, it was decided to create a bank of questions that would help coaches test their own knowledge regarding important issues such as heat exhaustion, weight loss in athletes, approach to common treatment programs and treatment of catastrophic injuries in sports, etc. These questions were compiled and sent as an insert in the *Medical Aspects of Sports Newsletter*.

The U.S. Sports Academy and the National High School Coaches Association are providing leadership in the area of coach certification. The Medical Aspects of Sports Committee supports their efforts and is willing to assist if called upon.

The Committee encourages local school boards to hire certified athletic trainers to work under the supervision of team physicians, and encourages physicians to participate as team physicians.

The Committee reiterated its willingness to serve as a speakers' bureau on sports medicine issues for any organization within the state.

The Committee wishes to go on record in support of MAG's position opposing legislation allowing therapists to treat without consulting a physician.

The Committee is making efforts to obtain information regarding the various sports programs within the state to better understand the present level of sports education and to predict future needs.

The Chairman expresses appreciation to the following members of the Sports Medicine Committee for their efforts in preparing the *Newsletter* and attendance at meetings:

Fred L. Allman, M.D.; John F. Atha, M.D.; Robert L. Brand, M.D.; Robert W. Crow, M.D.; Greg Foster, M.D.; J. Nicholas Gordon, M.D.; James F. Hammesfahr, M.D.; Stephen C. Hunter, M.D.; William B. Mulherin, M.D.; William B. Strong, M.D.; David T. Watson, M.D.; Richard S. Winer, M.D.; Mrs. John A. Fountain (Carolyn) and MAG Staff: Mrs. Talitha Russell.

### MEDICAL SCHOOLS COMMITTEE

**William C. Waters, III,  
M.D., Chairman**

**A**t its meeting last spring, the Medical Association of Georgia House of Delegates voted that our Committee should sponsor on an annual basis the previously biennial MAG Conference on Medical Education. We have complied with this directive, and accordingly last October held a very fruitful symposium.

Since 1965 MAG's Conference on Medical Education has been held to bring academic and practicing physicians together to discuss subjects of mutual concern. We keep our group of invitees small, to ensure a format for informal and free discussion. Among our forty attendees last October were deans, faculty and other representatives from each of Georgia's four medical schools along with leaders and members of our own association,

chiefly from our MAG Committee on Medical Schools.

The agenda for our most recent Conference was substantial and wide-ranging: national trends in medical education, financial pressures affecting full-time faculty, the declining student applicant pool, influencing students and residents toward primary care specialties and practice in underserved areas, licensure of FMG's, the proposed training of "registered care technologists," and the use of laboratory animals in biomedical research.

I would like to summarize our discussions on these points.

**DECLINING APPLICANT POOL TO MEDICAL SCHOOLS.** Harry P. Jonas, M.D., the American Medical Association's Director of Undergraduate Medical Education, addressed national trends in medical education, among the most significant of which is the declining number of applicants to U.S. medical schools. For the sixth year in a row, first-year enrollment in the nation's medical schools has decreased. We discussed various reasons for this disconcerting trend: increasingly attractive or remunerative non-medical career options for scientifically inclined students; students' concerns over malpractice insurance problems, government regulation of medicine and the high cost of medical education; and finally the advice being given by some physicians discouraging students from entering medicine.

Dr. Jonas also explained the growing trend toward the evaluation of educational outcomes, i.e., advice from the federal Department of Education to medical schools that they must track their graduates' choices of specialty, practice patterns, etc. While some schools are doing this, there is legitimate concern over *what* criteria should be used to evaluate a physician's education. How does one measure empathy toward patients, a primary



trait of a competent physician? Inability to measure this and other factors makes "evaluating educational outcome" difficult, if not impossible, for the medical profession.

Dr. Jonas also led us into discussion of a significant subject we talked about at our 1987 Conference, the financial pressures in medical education today. Increasingly, as federal funding grants to medical schools have dwindled, faculty practice plans are being used to produce income. This trend, of course, has exacerbated in many cases the traditional town-gown friction. Dr. Jonas reminded us of the current "town-town" competitiveness, and Dr. Pruitt of the Medical College of Georgia School of Medicine spoke as well of a "gown-gown" friction among schools.

We also heard from Dr. Garland Perdue of Emory on the controversy being caused today by opponents of the use of laboratory animals in biomedical research. He stressed that such animal use was vital, adding that anti-vivisection groups' activities are driving up the cost of medical education. Our attendees agreed that the MAG's statement in favor of the humane, regulated use of research animals needs to be adhered to, and that the controversy should continue to be monitored by MAG.

On Saturday morning we considered the declining numbers of medical school graduates choosing primary care specialties, especially internal medicine, pediatrics, and family practice. While recognizing that adjustments in Medicare payment levels being proposed by the Harvard Resource-Based Relative Value Scale study may make these "cognitive" specialties more attractive, we discussed the dangers to our profession being raised by interspecialty divisiveness.

We tried to get at the factors which lead students to choose certain specialties. Dr. Skelton expressed his concern for the mixed

messages we may be giving to our future physicians: "here's where the need is, but there's where the rewards are." We seemed to concur that academic and practicing physicians should coordinate efforts in advocating the many non-pecuniary rewards of practicing medicine.

Another of our topics was the problem of attracting physicians to underserved areas of Georgia, particularly rural locales. Ms. Denise Kornegay reviewed findings of the Governor's Task Force on Rural Hospitals, and enumerated recommendations of the report, including changes in the CON process, scholarships for allied health professionals choosing rural practices, and subsidies for rural malpractice premiums. We also learned how the Joint Board of Family Practice seeks to get primary care residents into rural settings. Dr. Skelton introduced the problem of funding graduate medical education, and recommended that our group support an increase in resident capitation funding from the state. We voted our support for this idea.

Finally, Dr. Bailey provided us with details on the AMA proposal for training a "Registered Care Technologist" as a means of addressing the nursing shortage. He noted that the AMA plan calls for a number of "pilot" programs in various states, one of which would be in Georgia. After discussing the program, we took a "straw poll" on it. Results showed we were divided on its efficacy: 8 for, 6 against.

Our Medical Education Conference this fall will be held in Athens, October 6-7. We appreciate your support of this meeting, and hope you agree with us that it brings about a fruitful communication among the academic and private practicing medical communities in our state.

I'd furthermore like to express my sincere appreciation to our hard working Committee members: Al Carr, M.D., S. William Clark, III, M.D., Lois T. Ellison, M.D., Frank L.

Ferrier, M.D., James S. Maughon, M.D., William M. McClatchey, M.D., George W. Shannon, M.D., and H. Kenneth Walker, M.D.

And as final note, I would be egregiously remiss were I not to mention the outstanding work of MAG staff member Stephen Davis, Ph.D.

## MEMBERSHIP EXPANSION & INVOLVEMENT COMMITTEE

**Bob G. Lanier, M.D.,  
Chairman**

**T**he MAG Membership Expansion and Involvement Committee met twice during the past year.

### Primary Goals for 1989-1990:

The Committee's major thrust for the upcoming year will be improvement and expansion of our prospective members database, utilizing information available from the Composite State Board of Medical Examiners, the AMA, Georgia specialty societies and possible other sources. Information collected will then be distributed to the component and district medical societies for refinement and solicitation.

By accumulating data from these available sources and updating MAG's existing nonmember file, the Committee will target specific classifications of potential members, inviting membership.

### On-Going Recruitment Efforts:

#### *Physician Movement Reports*

We continue to receive weekly Physician Movement Reports from the AMA. Lists provided are reviewed and the membership information system is updated by adding new physicians and updating nonmember records. New prospec-



tive member lists are distributed to component societies for recruitment.

## *AMA Direct Member Reports*

Printouts are forwarded to MAG from AMA, indicating those physicians in Georgia who have paid AMA dues directly to the AMA rather than through the usual county-MAG channels. The MAG database is updated with listings of additional potential members and printouts are forwarded to component societies for perusal. Physicians eligible for membership are invited to join.

## *Newly Licensed Physicians*

The Composite State Board of Medical Examiners continues to supply us with lists of physicians who are issued licenses to practice medicine in Georgia. With the exception of the out of state physicians listed, an individual letter inviting membership is sent to each new licensee. The computer system nonmember file is updated to list new licensees as prospective members.

## *Residents*

Semi-annually, lists are obtained from the AMA of residents in Georgia. These lists are compared to data currently on the MAG computer system, and records are added and updated. Residents not previously listed on the system are sent letters of invitation to membership.

## *Special Recruitment Projects*

Various other recruitment mailings and projects are continued throughout the year, including jointly working with the Division of Education to attract members to affiliate with MAG and its Medical Student Section, Resident Physician Section and Young Physician Section.

## **MMA/MAG Joint Sponsorship Membership Campaign**

Throughout the year, the Committee has kept abreast of the mem-

bership recruitment and retention program of MAA, jointly sponsored by MAG.

The theme of the project is "Join the Team," and was established to reverse the trend of decreasing active membership by conducting a highly visible peer-to-peer recruitment campaign to enlist and involve all eligible physicians in the metro area into MMA-MAG membership.

Several meetings were held to discuss proposed activities, with involvement of Committee representatives, MAA, MAG and MAG Mutual staff, to investigate the plans and benefits available through group participation.

The Medical Association of Atlanta will have a report indicating results of the project available within the next two months.

The Committee wishes to implement similar programs throughout the state, with the MAA campaign as a model.

## **MAG Delinquent Members**

In August, the Committee requested component societies to contact delinquent members in their areas, requesting continued participation. The number of members who did not pay was decreased by 108 as a result.

Members whose dues were not received by April 1, 1989, were dropped from the membership rolls, in compliance with MAG's Bylaws. As of March 27, 832 members had not renewed. Third notices for membership dues were forwarded, in addition to a special letter from MAG's President, and lists of delinquents were sent to component societies. By April 4, the number of members delinquent with 1989 dues was decreased by 412, with 420 remaining 1989 delinquents.

Ongoing follow-ups will be made to urge continued participation in the federation.

## **Committee Membership Attendance**

In order to increase attendance and interest in Committee meetings and allow a more equal geographical and specialty member distribution, as a directive of the 1988 House of Delegates, the Committee contacted Georgia specialty society and district representatives, requesting suggestions for members of these groups who would be interested in participation.

Three specialty groups which were not previously represented added members to the Committee: Neurology, Plastic Surgery and Urology; additional members were added representing Anesthesiology, Pediatrics and Radiology. Additionally, District representation on the Committee membership increased for Districts 1, 4, 5 and 6.

It is hoped that meeting attendance will soon increase by the addition of these new members.

## **Review of MAG Members vs. MAG Mutual Policyholders**

At MAG Mutual's request, a listing of MAG Mutual's policyholders was compared to the MAG masterfile for verification of MAG membership.

MAG Mutual's records indicated 575 of its policyholders as nonmembers of MAG, however, results indicated 116 of those as MAG members, 30 as pending members and one deceased.

MAG Mutual will utilize this information to update its database and nonmember surcharge files.

## **Resident Membership**

Since MAG Mutual's policy regarding payment of county and state membership dues for new resident members' first year of membership was changed to an offer of payment of county and state dues for physicians in their last year of residency, data was collected from county societies and the AMA to determine PGYs on Georgia physicians.



This information has been added to the MAG database, and letters from MAG-MAG Mutual have been mailed to 491 nonmember residents and 116 member residents with a PGY of 1989. During the past two months, 35 residents have replied to MAG Mutual's offer (10 renewals and 25 new members).

#### *Resident Orientation Program*

Last summer's recruitment effort by MAA and MAG at a two day Grady Hospital resident orientation program attracted an additional 128 new resident members as a direct result of the distribution of applications and accompanying materials.

#### **MAG-Specialty Society Membership Comparison**

A study is being done to determine how many members of each Georgia specialty society are MAG members. Although several societies have not yet forwarded lists of their members to MAG, of the seventeen groups whose membership listings have been researched, five fall below 60% MAG membership.

When comparisons have been completed for all societies, specialty society presidents will be contacted, urging invitation of MAG membership to societies' nonmembers.

The feasibility of adding a field on MAG's database to indicate specialty society membership is currently being investigated.

#### **Membership Brochure**

The Committee is presently reviewing information which has been compiled for a "county-generic" membership brochure, which would be appropriate for inclusion in mailings to physicians across the state.

#### **Current Membership**

MAG membership has increased to a total of 7039 members. Dues collections are up, with the October-March period reflecting 1989 dues paid by 5175 members; 4700

had paid during the same time frame of 1988.

#### **Component Societies**

The Committee has again been reviewing societies in rural areas which are not meeting the standards for societies as described in Chapter VIII, Section 7 of MAG's Bylaws, which include: meeting four times per year; maintaining an up-to-date Constitution & Bylaws; maintaining a Board of Censors or Mediation Committee; maintaining minutes of the society; maintaining programs of society meetings; maintaining rosters of society members and notification of changes to MAG; and notification of MAG of society actions which may affect membership.

At this writing, five societies have no society officers on file at the MAG headquarters office; two of these and an additional four societies have less than five active members.

District Directors were contacted earlier in the year, in an effort to assist societies and members in those areas to reorganize and participate more actively in organized medicine.

Since several societies seem unable to attract sufficient members to comply with the Bylaws, the Committee wishes to support a Bylaws amendment to include a category of "at-large" membership, to provide continuity of MAG membership for physicians in these rural areas.

## **PRISON HEALTH CARE COMMITTEE**

**Robert H. DeJarnette, Jr.,  
M.D., Chairman**

**T**he Prison Health Care Committee met three times in the past year under the leadership of

our Chairman Robert H. DeJarnette, Jr. The contract for fiscal year 1988-89 with the Georgia Department of Corrections was for a total of \$46,896. For the full year preceding the date of this report, March 20, 1989, the total income from accreditation fees paid to MAG is \$10,300. Most of these accreditation fees are used as consultant fees and reimbursement or travel expenses paid to physicians who are members of this Committee. The physician members of this Committee continue to participate on all accreditation and reaccreditation site visits conducted. Funding for the project and fees are expected to remain at this level for the next year.

Georgia State prisons that have been reviewed for accreditation since the last annual report of this Committee are Augusta Correctional and Medical Institution, Augusta, Georgia; Lee Correctional Institute, Leesburg; three Institutions at Hardwick, that is, Men's Correctional Institution, Youthful Offenders Correctional Institution, and Rivers Correctional Institution; Georgia Industrial Institute at Alto, Georgia Diagnostic and Classification Center at Jackson, and Al Burrus Correctional Training Center in Forsyth. All of these facilities were reaccredited by the Committee for 2 full years except that we are waiting on structural modifications to the Infirmary at Rivers C. I. in Hardwick. Upon revisiting to review changes requested by the Committee this facility will also be reaccredited for 2 years. Al Burrus Correctional Training Center will receive 2 year reaccreditation upon implementation of mental health evaluation services.

Jails that were visited during the same period include Chatham County Jail in Savannah, Forsyth County Jail in Cumming, Chattooga County Jail in Summerville, Randolph County Jail in Cuthbert, Taylor County Jail in Butler, Hall County



Jail in Gainesville, and Walton County Jail in Monroe.

Most jail facilities were reaccredited for 2 years. However, there were a few jails with some difficulties: the Randolph County Jail in Cuthbert and the Taylor County Jail in Butler. Each facility has various problems which we expect can be corrected by the Committee's next meeting in June. Both facilities will be revisited to monitor implementation of recommended changes before that date.

Perhaps the highlight this year for the Committee was the presentation of a recognition award made to The Medical Association of Georgia "For its concern that incarcerated adults and juveniles receive adequate medical care and its participation in the nationwide accreditation program for prisons, jails, and juvenile facilities." This award was presented on November 2, 1988 at Lake Buena Vista, Florida at the conference of the National Commission on Correctional Health Care. The award was presented by the Commission's President, Bernard Harrison, to representatives of MAG Committee on Prison Health Care, Floyd E. Bliven, Jr., M.D.; Charles A. Meyer, Jr., M.D.; and Dorothy Parker, MAG Staff.

During the year the Committee set up a subcommittee for the purpose of developing a plan whereby this Committee would become actively involved in the accreditation of Georgia's juvenile detention centers. Heading up this effort is Bethanne F. Jenks, M.D., member of this Committee. Other subcommittee members are Charles A. Meyer, Jr., M.D.; Louis Scharff, III, M.D.; Bobby C. Burnley, R.P.H.; and Dorothy Parker, MAG staff. Preceding the appointment of the subcommittee, Dr. Jenks surveyed Georgia's juvenile institutions and presented results to the Committee which indicated a very common experience of limited and inadequate services being provided. This finding compares to earlier studies regarding county

jails. Four preview visits were conducted by Dr. Jenks and Dorothy in 1988. The subcommittee met in August of 1988 and established goals; most important: a first accreditation site review would be made at a juvenile facility before the end of 1988 and a second by the spring of 1989. Dr. Jenks and Dorothy met with the director of the Georgia Department of Youth Services, Marjorie Young. After this meeting a schedule for accreditation of juvenile facilities was considered. Subsequently, a first site visit was conducted at the Atlanta Youth Detention Center in Adamsville on Feb. 28, 1989. The findings of that site visit were presented to our Committee on March 12, 1989. It was decided that health care is very good, but several programs implemented prior to our visit would need more time before being ready for accreditation. They will be reviewed again before June 4.

The Training program designed by the MAG Committee on Prison Health Care, "Abnormal Behavior in the Correctional Setting," was presented at the Georgia Public Safety Training Center in Forsyth, GA on 5 occasions during 1988. This training program was co-sponsored by MAG and the Georgia Sheriff's Association. Funding for training of jail officers came under the budget of the Georgia Public Safety Training Center and thus much of these costs were covered by this agency and Georgia sheriffs were relieved of much of this cost. With this funding arrangement, sheriffs are more likely to send officers for training. Consequently, 135 jail officers were able to complete this training during the year. Also, there was one training session held in October for nurses and other health personnel who work in local county jails. This was a very successful training program and several very important and interesting issues regarding the provision of health services in jail were brought up in this session. There is a need for the continuation

of similar training sessions and especially the nurses training workshop. Unfortunately, in December 1988, a letter was received from the Georgia Public Safety Training Center indicating that funding for the jail programming such as we have presented, will no longer be available. This means that future training will very likely be paid by the Sheriffs and this will lead to reduced enrollment for such classes. However, we will continue to seek means by which these training programs may be continued and will continue our co-ordination with Georgia Sheriff's Association to provide programs to benefit the delivery of health services in local jails.

In early April of 1989, the Georgia Chapter of American Correctional Health Services Association presented a conference entitled "The Invisible System: Public Health Care Behind Bars." The conference was presented at Unicoi State Park Conference Center at Helen, GA. Some of the principal speakers at this conference are Jaye Anno, Vice President of the National Commission on Correctional Health Care; Doug Skelton, M.D., Dean of the Mercer University School of Medicine; and Joseph Wilbur, M.D., Medical Consultant to the Infectious Disease Program at the Department of Human Resources, and Dr. John Gates, Director of the Division of Mental Health and Mental Retardation of the Georgia Department of Human Resources. Both Dr. Skelton and Dr. Wilbur are former members of the MAG Committee on Prison Health Care. Dr. Jaye Anno is a former Director of the AMA Correctional Health Care Program.

This Committee appreciates the support given by MAG and respectively submits this report as information on the progress experienced during the past year.



## SCIENTIFIC ASSEMBLY COMMITTEE

**Roland S. Summers, M.D.**

Our recent Scientific Assembly, held last November 11-13, was another very good meeting.

Nine Specialty Societies chose to offer CME programs with us this time. Our final registration figures break down thus:

Allergy & Immunology	31
Chest Disease	49
Neurology	52
Neurosurgery	42
Ophthalmology	103
Otolaryngology	48
Pathology	129
Plastic Surgery	48
Psychiatry	56
Total	558

This total is down from our 1987 meeting, but can be explained in a couple of ways. At our recent meeting, we didn't offer programs in Surgery and Ob/Gyn, which drew some 200 attendees to our 1987 meeting. Another factor may also have been that we conflicted with a big football game (Georgia-Auburn) on November 12. We tried to avoid this conflict, but couldn't work things out with the hotel. Hence this most recent meeting was held a week earlier than our usual time.

This coming fall, however, we're back on track with our schedule, and will once again hold our 1989 meeting during the weekend before Thanksgiving (free of major ball games).

Here's a run-down of our upcoming schedule, in fact:

### MAG SCIENTIFIC ASSEMBLY

November 17-19, 1989  
Ritz-Carlton Buckhead Hotel  
November 16-18, 1990  
Ritz-Carlton Buckhead Hotel

November 16-19, 1991

(with Southern Medical Association)

The Ritz Buckhead remains a popular site for our meeting. Our attendees say consistently good things about it, and don't want us

to move. What's more, the Ritz likes our business. It gives us reasonable room rates (for 1989, \$96 s/d), and bends on its usual rule prohibiting table top exhibitors in the foyer of our meeting room area.

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### FINANCIAL REPORT — 1988 SCIENTIFIC ASSEMBLY

#### INCOME

Registration fees	\$29,695
Exhibitors	2,500
Pharmaceutical Grants	1,000
	<u>\$33,195</u>

#### EXPENSES

Specialty Society Reimbursements	\$11,600.00
Hotel	7,792.67
AV — Corporate AV	4,413.81
Publicity	
Postage — Psych & Path	627.90
Printing — Psych & Path	737.54
Labels — APA, CAP	270.00
Signs — Freeman Company	354.37
Postage — Society Mailing	1,043.49
Miscellaneous office	145.00
Ovid Bell Press, Inc. — Registration insert	1,198.75
Kinko's	105.96
Alpha Printing — final program	345.00
Alpha Printing — CME certificates	90.94
Postage — CME certificates	59.54
	<u>\$28,784.97</u>

#### SUMMARY — 1988 SCIENTIFIC ASSEMBLY

INCOME	\$33,195.00
EXPENSES	<u>28,784.97</u>
	\$4,410.03

The bottom line, as you see, shows us slightly in the black — just where we want to be.

Thank you for your continued support of our meeting.

## COMMITTEE ON SPECIALTY SOCIETY RELATIONS

**Ellis B. Keener, M.D.,  
Chairman**

The Committee on Specialty Society Relations met on November 11, 1988, during the MAG Scientific Assembly. It also carried on

telephone and written communications with all of the specialty societies that comprise the membership of the Committee.

The Committee concentrated on three matters during the year. They were: (1) Informed Consent; (2) New specialty society memberships on the Committee; and (3) Bylaws amendment to authorize election of delegates and alternate delegates from each of the specialties to the MAG House of Delegates.

The new Informed Consent law enacted by the Georgia General Assembly had an effective date of January 1, 1989. It was clear to MAG and to the MAG Mutual Insurance Company that much preparation needed to be done on very short notice. The game plan called for each different specialty to design a consent form tailored to each procedure performed by the practitioners of that particular specialty.

To assist in this endeavor, the Specialty Society Relations Committee devoted a portion of its meeting to Mr. Tom Gose, President of MAG Mutual, to discuss this issue with the Committee members. The Committee members, in turn, would pass this on to the leadership of their own specialty.

In addition, all specialty society presidents were written and telephoned in a concentrated effort to "get the word" spread to all the members of their particular societies.

Membership on the Committee on Specialty Society Relations signifies official recognition of that society by the Medical Association of Georgia. The criteria used to determine the appropriateness of membership by a medical specialty society is under periodic review and is always used when any new society has petitioned for membership.

At its meeting on November 11, 1988, the Committee carefully considered the petitions of two specialty societies seeking member-

ship. They were: (1) the Georgia Society of Physical Medicine and Rehabilitation; and (2) the Georgia Occupational Medical Association. In the opinion of the Committee, both of these societies met the criteria for membership (membership criteria was adopted by the MAG Board of Directors in September 1983) and accordingly were recommended favorably to the Board of Directors in January 1989. The Board voted to add these societies to the Specialty Society Relations Committee. As a result of this Board action, the Committee now has 27 officially recognized members. They are:

Allergy & Immunology, Family Physicians, Pathology, Gastroenterology, Orthopaedics, Psychiatry, Radiology, Rheumatism, Thoracic, Urology, OB-GYN, Pediatrics, Public Health, Emergency Physicians, College of Physicians, College of Surgeons, Anesthesiology, Dermatology, Internal Medicine, Nuclear Medicine, Ophthalmology, Otolaryngology, Plastic Surgery, Neurology, Neurosurgery.

The House of Delegates at the Annual Session in 1988, accepted an amendment to the Constitution that would authorize a voting Delegate and an Alternate Delegate from each specialty society represented on the Specialty Society Relations Committee. If this amendment is adopted by the 1989 House of Delegates, it would then be necessary that the House adopt a Bylaws amendment to specify the details to insure an orderly election of Delegates and Alternates.

Pursuant to that, the Committee drafted an amendment to the Bylaws and forwarded it to Dr. J. Rhodes Haverty, Chairman of the Constitution and Bylaws Committee on November 30, 1988, in time to comply with the 45-day rule that governs amendments. It is our hope that this will be included as a part of the report of the Committee on Constitution and Bylaws and pre-

sented to the House of Delegates for a vote at the 1989 meeting.

I want to thank all the representatives of the specialty societies for their participation in the business of the Committee.

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### AD HOC COMMITTEE ON TORT REFORM

John D. Watson, Jr., M.D.

**T**he Committee met several times during 1988 in its continuing study of Tort Reform and various solutions to the liability crisis in Georgia. MAG staff and MAG Mutual staff exerted considerable time and energy in researching various alternatives. After considerable discussion, it was decided by this Committee and the MAG Executive Committee to support a multi-pronged legislative tort reform agenda. The major components of this agenda were: (1) mandatory binding arbitration in ob cases; (2) a change in the standard of proof to require scientific certainty as to negligence; and (3) a revision of the expert witness definition.

During numerous discussions with physicians who deliver babies, it was clear that a major crisis is building in this state leading to the destruction of the current system of obstetric care delivery. In the last four years, there has been a dramatic decrease in the number of Georgia physicians who are still willing to deliver babies. Additionally, statistics show that obstetricians are retiring at an earlier age, many residents are refusing to enter this critical field of medicine and numerous family physicians are no longer delivering babies. In response to this growing crisis, your Committee recommended (at the request of the obstetrical societies) that MAG develop a fault-based



mandatory binding arbitration statute for introduction in the Georgia General Assembly. Tremendous resources were utilized in the development of the model legislation. The General Counsel of the American College of Obstetricians/Gynecologists, attorneys from AMA, private counsel from a Washington, D.C. law firm specializing in liability issues, MAG Mutual staff and attorneys, and numerous physicians, including prominent obstetricians were consulted and directly participated in the drafting of the legislation that was eventually introduced as H.B. 1011 by Representatives Pete Robinson, Wesley Dunn, Larry Walker, Denmark Groover, Tommy Chambless and Terry Coleman.

MAG also solicited and received the support of Lt. Governor Zell Miller. Speaker of the House Tom Murphy was very receptive to finding solutions to this problem that he too recognized as a growing concern. Speaker Murphy related his personal awareness of the problem because his grandchildren had to be born in Cobb County "by Republican doctors" since none of the physicians in his home county deliver babies anymore. Public hearing will be held over the summer in both the House and Senate debating this vital issue. The House will be studying H.B. 1011; whereas the Senate has established a special study committee for the specific purpose of finding solutions to this growing problem. Senator Nathan Deal introduced this study committee as S.R. 267.

The Committee is attaching a copy of H.B. 1011 to this report because we feel that it is one of the most significant tort reform bills ever introduced in this state. (Ed. note: Contact Richard Greene at MAG for a copy of this legislation.) In fact, there is not a state in this nation that has comparable statute. We are aware that this approach is experimental and perhaps even contains some pitfalls; however, it is felt that

a bold and dramatic response is necessary to resolve this dramatic problem. We urge each of you to read H.B. 1011, become familiar with its contents and concepts, and then — most importantly, talk to your legislators. It is up to *you* to educate them on this vital piece of legislation. *You* must get their commitment of support for H.B. 1011.

The "standard of proof" issue mentioned in the opening paragraph was incorporated into the arbitration bill. It states that before a physician can be found negligent in a ob case (i.e. "ob" when used in this report refers to any physician who delivers an infant or is directly involved in the delivery such as an anesthesiologist), that there must be expert medical testimony confirming — based upon *scientific evidence* — that the injury is related to a negligent act of the physician. It is felt that this particular standard, if passed, will be of significant value in defending ob cases where there frequently is no negligence on the part of the physician but the jury is confronted with a sympathetic plaintiff (an infant or young child in need of significant long-term health care).

Another major bill, H.B. 1135, was introduced by Representative Wesley Dunn. It is an attempt to re-define an "expert witness" in medical malpractice cases. This legislation would require that a medical expert for both the plaintiff and the defense would have to have actively practiced in the medical specialty or area of practice before the court for at least three of the last five years preceding his service as an expert witness. Experience has shown that many "professional" experts are not truly qualified to practice — much less testify — about the complicated medical issue under consideration by the Court. This legislation would prohibit that which recently took place in an obstetrician's case where the only plaintiff's expert was a psychiatrist who

allegedly had not delivered a baby since his intern days.

Your Ad Hoc Committee on Tort Reform had an active and productive year in researching and developing legislation. It is now up to *YOU* to contact your patients and legislators to educate them on the importance — yes the necessity — of passing these critical pieces of legislation.

## AD HOC COMMITTEE ON DIVERSION OF LEGITIMATE PRESCRIPTION DRUGS

**Milton I. Johnson, Jr.,  
M.D., Chairman**

**T**his Committee has existed for several years and has held numerous hearings and discussions.

The Committee recommended in 1988 that the triplicate prescription blank program as a method of aiding in the control of the problem of diversion of legitimate prescription drugs be recommended to the House of Delegates for consideration. The 1988 House then referred this issue to the Legislative Council for further study. The Legislative Council then presented its report to the Board of Directors.

In September, 1988, the Board of Directors heard a presentation by Bonnie B. Wilford of the American Medical Association advocating the Prescription Abuse Data Synthesis (PADS II) program as a method of controlling the problem. The Board then voted to oppose the triplicate prescription program and to support alternative approaches such as PADS II.

There have been numerous conversations between officers, administrative staff, the Attorney General,



GBI, the Governor's office, Criminal Justice Coordinating Council, other state officials, pharmacists and other concerned health professionals regarding legislative action to correct this problem.

Prior to those meetings, we had expected the Attorney General's Office to cause a triplicate prescription bill to be introduced at the 1989 session of the legislature but this did not occur. However, it is probably only a question of time until someone takes legislative action. The Attorney General appears to be determined to introduce such legislation.

MAG's staff is continuing to work with the appropriate officials and groups to develop an alternative approach such as PADS II.

The Committee has not met this year but makes this report to update the House of Delegates on developments.

## PRO REVIEW COMMITTEE

**Joseph C. Stubbs, M.D.,  
Chairman**

**T**he PRO Review Committee and representatives of the Georgia PRO/GMCF spent numerous hours reviewing two major potential problem areas for 1989, and beyond: the HCFA required PRO Scope of Work for the next Georgia PRO Contract (effective April 1, 1989) and HCFA Proposed Regulations to set forth the rules by which Utilization and Quality Control Peer Review Organizations would deny payment for substandard quality care (these changes are required as a result of the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985, enacted on April 7, 1986, and the passage of the Omnibus Budget Reconciliation Act of 1987, enacted on December 22, 1987). These proposed regulations also set

forth changes to govern Peer Review Organization review of beneficiary complaints about quality of care in accordance with the Omnibus Budget Reconciliation Act of 1986, enacted on October 21, 1986.

### Scope of Work/Quality Intervention Plan

GMCF Policy Statement: Discharge and quality of care review will be performed on all cases reviewed by GMCF, using GMCF's ISD discharge screens and HCFA's generic quality screens, as applicable to the hospital setting being reviewed, i.e., Acute Care/Specialty. Except as specified in the generic screen exclusions (i.e., cases where certain quality screens are not applicable, such as deaths, transfers, AMA's etc. . . .), each case failing one or more screens, and determined by the nurse to represent potential quality problems, will be referred to a GMCF physician for review. Although nurse reviewers can determine that a screen failure does not indicate a quality problem, it should be emphasized that, only a physician reviewer can confirm a quality of care problem. A brief outline of changes from the current system follows:

#### I. Definition of Severity Levels

To facilitate data collection of the results of quality review, and ensure national consistency, HCFA requires the utilization of the severity level system outlined below:

1. Medical mismanagement *without* the potential for significant adverse effects on the patient (Level I);

2. Medical mismanagement *with* the potential for significant adverse effects on the patient (Level II);

3. Medical mismanagement *with* significant adverse effect on the patient (Level III).

Note: Georgia currently uses 5 levels.

#### II. Quality Review Process and Problem Identification

#### A. Nurse Review Process

Greater emphasis is placed on documentation of problems. Screen failures for Level I severity levels will be pended until a pattern of potential problems is established through profiling (i.e., 3 cases per quarter). At this point, cases would be referred to physicians review.

#### B. Physicians Review Process

The new scope of work will require PROs to establish review by the appropriate speciality and by representatives of similar practice settings. The GMCF incorporated this practice in its review some time ago. If potential severity Level II or III problems are identified, the responsible party must be given the opportunity to respond within 30 days (expansion from current 20 days limit). The notice must also contain enough detail to clearly identify the problem.

#### III. Content to Notice of Confirmed Quality Problems

The responsible party (i.e., physician/provider) must be notified of the final determination in each case, regardless of severity level. This, also, includes cases where the quality of care is determined to be appropriate during physician review. Where the quality problem is confirmed, the notice of final determination will include the following:

1. A description of the confirmed quality problem;

2. Suggested alternative course of action; (Editorial Note: The extent to which this will be implemented is undetermined at the time of this report)

3. The severity level for the quality problem; and

4. The immediate interventions to be initiated, if applicable, and/or potential interventions on the identification of patterns through on-going profiling.

#### IV. Quarterly Profiling

PRO's will be required to build a data base relative to quality review. This will establish a profile of all



potential, as well as, confirmed quality screen, region, and LOS. In addition, such flexibility in profiling will provide the capability to identify specific practice patterns, associated with quality of care problems, for focused intervention. One good aspect of this profiling is the establishment of a bi-quarterly purging system which will allow termination of intensified reviews if no additional problems are discovered within two quarters.

#### V. Determining Weighted Severity Level Scores

This so called "point system" is perhaps one of the most confusing and controversial changes being made. A numeric value will be assigned to each confirmed quality problem based on its severity level as follows:

Severity Level	Score
I	2
II	5
III	25

The following formulas will then be used to compute the quarterly weighted severity level score by each problem source: Cases with Severity Level I Quality Problems  $\times 1 = A$ . Cases with Severity Level II Quality Problems  $\times 5 = B$ . Cases with Severity Level III Quality Problems  $\times 25 = C$ .  $A + B + C =$  Weighted Severity Level Score.

For example: During the January through March quarter, Dr. X had three (3) level II quality problems and four (4) level I quality problems.

Three level II cases  $\times 5$  (Level II score) = 15; 4 level I cases  $\times 1$  (Level I score) = 4;  $15 + 4 = 19 =$  Quarterly Weighted Severity Level Score for Dr. X.

*Note:* The assignment of certain scores do not necessarily result in certain interventions.

#### VI. Selection of Appropriate Intervention

The appropriate intervention will be guided by the severity and fre-

quency of the confirmed quality of care problems. The total weighted severity level score will serve as a guide for determining the appropriate type of intervention. The following table illustrates the triggers to be used in deciding on the appropriate intervention unless a decision to override that process is made by the Medical Director and/or Medical Review Committee.

Intervention	Weighted Severity Level Score
Quarterly Notifications	3 per quarter or 5 per bi-quarter
Educational Activities	10
Intensification	15
Additional Restrictions and Disciplinary Actions	20
Coordination with licensing bodies	25
Sanction Consideration	25

#### VII. Overriding Intervention Triggers

These interventions may be overridden by GMCF's Medical Director and/or Medical Review Committee, as applicable, in such a way as to apply a lower weighted intervention when it is determined that the identified quality of care problems are not significant enough to warrant the level of intervention, specified for the weighted severity level score.

#### VIII. Quality Interventions

##### A. Quarterly Notification

Patterns of confirmed quality problems will be included in a quarterly notice to specific physician/providers identified during quarterly profiling. Where additional interventions are being initiated, this letter will, also, serve as notification of these actions and expected outcome.

##### B. Educational Activities

The selection of appropriate educational activities will be guided

by the severity of the confirmed quality problem(s). This scope of work requires much greater emphasis on education. Specific medical literature or reference materials will be provided to physicians/providers, as applicable.

##### C. Intensified Review

The type of intensified review may range from a one time small random sample of specific cases to 100% of all cases for a maximum of one (1) quarter.

##### D. Additional Restriction and Disciplinary Action

These interventions will be restricted to physicians and/or providers associated with major quality of care deficiencies and/or established patterns of deficient practice behavior, unresponsive to remedial activities. These additional restrictions and/or disciplinary action may include but not be limited to, pre-discharge review, mandatory use of consultants, and referrals to hospital committees or referral to appropriate state regulatory authority, etc., in situations where quality of care problems represent severe deficiencies requiring immediate intervention to protect Medicare beneficiaries from inappropriate medical care and/or potential adverse effects.

##### E. Sanction Consideration

Physicians/providers failing to address and/or satisfactorily correct identified problems, within two (2) quarters, will be referred to the Medical Director and/or Medical Review Committee for sanction consideration. However, emphasis will be placed on education and modification of unacceptable practice patterns rather than on sanctions. A sanction recommendation to the Office of Inspector General (OIG) will be initiated only in situations where the Medical Review Committee determines that, a physician and/or provider demonstrates an unwillingness or inability to correct significant quality of care deficiencies, despite intense intervention.



### PRO Denial of Substandard Care

The January 18, 1989 Federal Register contained Health Care Financing Administration (HCFA) Proposed Rules to implement federal legislation (OBRA 1985, 1986 and 1987) relating to PRO review and possible denial of Medical payment to a physician and/or hospital for services that are determined to be of "substandard quality." This is in addition to the on-going Quality Assurance/Sanction process.

This proposal specified that payment would be denied "when . . . the care furnished results in an actual, significant adverse effect or presents an imminent danger to the health, safety or well-being of the Medicare beneficiary." If it is determined (after allowing for provider response) that substandard care was provided, the beneficiary would be notified directly that their claim was denied because of "substandard quality." As presented, this notification would occur prior to exhaustion of the appeals process.

The potential impact of this is of such magnitude that the MAG distributed this document to each county medical society, hospital medical staff and specialty society in Georgia for their comments either to the MAG or direct response to HCFA. Response deadline was March 20, 1989.

The PRO Review Committee met Sunday February 26 and made the following recommendations to the March 5 meeting of the MAG Executive Committee.

"Proposed Denial for Substandard Care." First and foremost the Committee feels that this law should be repealed. We are concerned about the quality of care all patients receive, but we believe that existing laws allow for patient redress and the Medicare Law providing for PRO review of quality of care and ultimate sanction addresses Medicare specific issues. We believe any regulations to implement this law will contain intrinsic exposure to lia-

bility and imposition of monetary penalties. This amounts to a sanction and should only be addressed through the complete sanction process already in existence.

If we are forced to deal with implementation, we strongly recommend that NO NOTIFICATION of the patient occur prior to the exhaustion of the *complete* appellate process and further that this complete process be available to all parties — not just the beneficiary. Any notification to the beneficiary that substandard care has been provided invites liability. The wording of this notification should be modified to simply state that payment is denied in accordance with Medicare provisions. It should be sufficient that the patient won't have to pay without deliberately inviting malpractice suits.

There should be provisions included to prevent discoverability of review records for possible liability situations. Any possible liability considerations should be completely separate from Medicare payment decisions. We are sure the U. S. Government through HHS/HCFA doesn't need nor desire to be involved in these situations.

The Committee recommends that all consideration of quality of care (both denial and beneficiary complaint) be conducted through the existing quality of care review process with emphasis on education and elimination of the problems rather than sanctions. It seems inappropriate to "back up" to a worse position than that which existed before the current review process evolved.

The Committee feels that the definition of substandard care is too broad. Specifically, it recommends that detail occur only if patient management results in physiological or anatomical impairment which results in disability or death.

The Committee further recommends that:

1. The *initial* determination of a quality of care problem *always* be

made by appropriate specialists, preferably a committee.

2. The proposed use of HCFA guidelines for review be clarified. In accordance with the discussion and Dr. Murphy's understanding they should only provide a general framework yet the proposed regulations seem to require specific written guidelines that physician reviewers must use to determine whether the quality of care was substandard.

The Executive Committee approved these recommendations and a letter from Joseph P. Bailey, Jr., M.D., MAG President, was forwarded to HCFA with copies to the AMA and Georgia Congressional Delegates.

### Hospital Medical Staff UR Committee Notification

In addition to Committee recommendations regarding the PRO Denial for Substandard Care, the Executive Committee also approved the Committee recommendation that the Hospital Medical Staff Utilization Review Committee routinely receive a copy of the original notice of a possible quality of care problem with the stipulation that the physician notice be annotated that a copy had been sent to the UR Committee for the sole purpose of seeking its assistance in response to the issue cited.

The Committee favors this action because response to the original notice is vital, the UR Committee can provide invaluable assistance to the physician in dealing with these problems; the physician may for one reason or another, miss the original letter and the UR Committee could make sure the physician is aware of the problem; and, the hospital medical staff is responsible for the quality of care provided. The proposed denial for substandard care regs specify that the hospital is responsible for *all* substandard care — i.e., the hospital bill will always be denied.



### Preadmission Procedure Prior Approval

OBRA 85 established the policy of PRO prior approval for certain elective procedures. OBRA 87 mandated PRO prior approval of at least 10 procedures, to be selected locally on the basis of high volume, substantial variation in charge rates and/or procedures which could be postponed without high risk to the patient. This requirement is to be implemented with the third scope of work as PRO contracts are renegotiated. Agreement on the Georgia contract was not reached until March 29 implementation due April 1, 1989. Because of its uncertainty, the GMCF suspended prior approval activities the last two weeks in March.

With the new contract, the GMCF has selected the following 10 procedures from a list of 13 furnished by the Health Care Financing Administration (HCFA): Cataract Extraction; Carotid Endarterectomy; Coronary Artery Bypass with Graft; \*Pacemaker Insertion; Percutaneous Transluminal Coronary Angioplasty; Complex Peripheral

Revascularization; Hip Replacement; Laminectomy; \*Hysterectomy and \*Prostatectomy. (\*procedures previously required prior approval).

The GMCF mailed detailed information, including the process for prior approval and criteria applicable to each procedure to all hospitals and to physicians of each relative speciality on March 30 and 31. The GMCF assures us that the criteria for these procedures are intended to be an evolving process. They are available to physicians through their respective facilities or upon request to the GMCF.

For preadmission approval, a representative of the hospital, ambulatory surgical center (ASC), or physician's office must call the PRO (GMCF — not Aetna) at 1-800-822-9707 or 404-982-0037. Persons calling should be prepared with appropriate patient and provider identification and specific detail regarding indications for the procedure to be performed. You may experience a temporary delay getting through because of the 2 week suspension and short implementation time.

GMCF will have nurse reviewers

available to receive calls from 9:00 a.m.-5:00 p.m. Monday-Friday. If the case cannot be approved by the nurse reviewer, it will be referred to a GMCF physicians consultant. In cases where prior approval cannot be obtained within these hours, e.g. emergencies, calls should be made early the first working day after the procedure is performed. Requests for preadmission/preprocedure review can be made up to two weeks (14 days) prior to the procedure. Requests made less than 48 hours prior to the procedure may require retrospective PREPAYMENT review.

If the procedure is approved, the requester will be given a Medicare authorization number by phone. This number must be shown in block 23B of the HCFA — 1500 claim form. All claims for payment of these ten procedures which do not have the appropriate Medical authorization code will be subjected to retrospective PREPAYMENT review. If a nonapproved procedure is performed neither the physician, hospital, nor ASC facility fee will be allowed, and the beneficiary cannot be billed.

# Second Session House of Delegates

May 6



*U.S. Congressman Ben Jones informed and entertained delegates and guests with his experiences both before and after his election to Congress.*

**T**HE SECOND SESSION of the MAG House of Delegates was called to order at 9:00 a.m., Saturday, May 6, 1989, in the Regency Ballroom of the Hyatt Ravinia Hotel in Atlanta by Speaker James A. Kaufmann, M.D.

Dr. Kaufmann asked for a report from the Credentials Committee which confirmed that a quorum was present. Because there were several contested races this year, Dr. Kaufmann reviewed the balloting procedures. Ballots were to be distributed after the Keynote Address of Congressman Ben Jones.

Congressman Jones spoke to the House following the report of Reference Committee C.

#### **Presentation of Legislators' Awards**

The following legislators received special awards for their loyal

support of MAG: Senator Jim Tysinger, Representatives Bill Lee, Tom Wilder, and Billy Randall.

#### **Reference Committee Reports**

The reports of Reference Committees A, B, D, F, C & B were then presented to the House. (Reference Committee C's report was presented earlier, prior to the address of the Keynote Speaker, Congressman Ben Jones.) These reports are printed in alphabetical order (with the exception of C&B which follows Reference Committee F) elsewhere in this *Journal*.

Following these reports, the Speaker recessed the House at approximately 3:30 p.m. with the reminder to attend the Installation Ceremony of new officers and the Presidents' Reception 6 'oclock that evening.



*Speaker James Kaufmann (R) presents State Representative Bill Lee with a Certificate of Appreciation for his support of medicine in the Georgia General Assembly.*



*State Representative Tom Wilder (L) is presented with MAG's Certificate of Appreciation by Dr. Dan Stephens, of Marietta.*

*State Representative Billy Randall (L) is another supporter of the medical profession at the Capital and was presented with MAG's Certificate of Appreciation by former MAG President Jack Menendez, of Macon. In the background are Paul Shanor, (L) Executive Director of the MAG, and Vice Speaker Jack Raines.*







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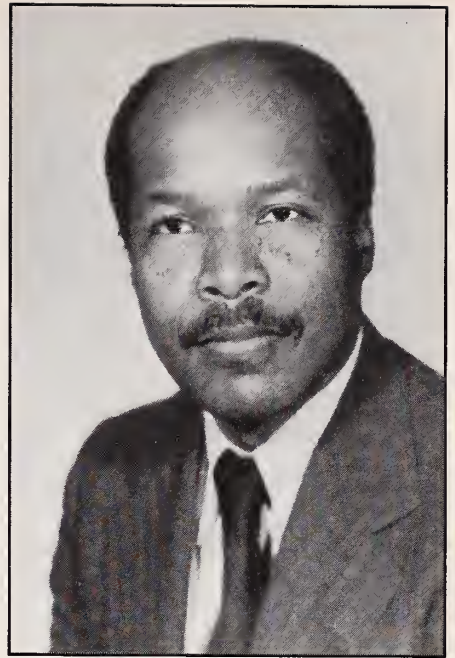
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# Dr. Louis Sullivan Addresses MAG House of Delegates

## Medicare Morass Major Focus of Remarks



*Dr. Louis A. Sullivan, Secretary of the U.S. Department of Health and Human Services.*

**E**ARLIER THIS YEAR, President George Bush tapped Louis W. Sullivan, M.D., as his Secretary of the Department of Health and Human Services. Dr. Sullivan, an internist/hematologist, was at the time President of Morehouse School of Medicine in Atlanta and on the editorial board of this Journal. (The latter position he still retains, as our Washington correspondent.)

As HHS Secretary, Dr. Sullivan faces the challenge of dealing with epidemics in illicit drug use and AIDS, preservation of Social Security, guaranteeing food and drug safety, poverty, and an array of other problems touching the lives of every American, from the unborn to the dying — critical issues that are literally shaping the future of this country.

Dr. Sullivan's speech to the MAG House of Delegates on May 4 was his first major address in this state since his appointment. He chose to concentrate on the health care crisis facing us and our elderly patients that came about this year with the change in providers of Medicare Part B Program.

*The following is from Dr. Sullivan's speech to the MAG:*

**A**s you can imagine, our work at The U.S. Department of Health and Human Services virtually touches the lives of every American. I have to address a plethora of concerns simultaneously:

- The AIDS crisis, and the need to continue research on education, prevention, and treatment for the over 80,000 Americans diagnosed with AIDS;
- The epidemic of illicit drug use, which is overwhelming our law enforcement and treatment capabilities;
- The disintegration of the traditional American family, which threatens to perpetuate and increase poverty, dependence, dropout rates, crime, and teenage pregnancy;
- The need to guarantee food and drug safety, which is a constant battle, as proven by the recent incidence with Chilean grapes and the British experience with baby food tampering;
- The preservation of Social Security, which is a social contract we must keep with our older citizens;
- The need to provide long-term care without creating a bureau-

cratic nightmare and further deepening our federal debt;

- The ways and means to enhance access to care for minorities and the poor, who are dying at higher rates than whites in practically every mortality category; and
- Many other items on President Bush's domestic agenda.

**I**would like to focus on two other important priorities this evening. Tonight I would like to discuss the need to maintain and improve the quality of care for our elderly citizens and the need to control escalating health care costs.

Last December 22, in my first statement to the Washington Press Corps after President Bush's announcement of my appointment, I talked about the need to preserve the financial integrity of Medicare and the need to maintain the quality of care for our citizens. From the very beginning, this has been my goal and, if you will, my personal mandate since I was sworn in on March 10, some 2 months ago. That mandate has already been tested, and by a situation which hits very close to home — the problems associated with Aetna Life Insurance as a Medicare carrier for the Medicare Part B Program.



I recently picked up a copy of the MAG newsletter. I was interested to see that my speech today was advertised as "a great opportunity" to hear how HHS is responding to the problems confronting Aetna. So I know that this topic is on your mind, too. Let me share my response with you.

**L**ast year, Prudential withdrew all of its Medicare contracts from the state of Georgia and nationwide. This was an unexpected development. Obviously, the Health Care Financing Administration had to find a new contractor on very short notice. After review of each potential contractor, the Aetna Insurance Company was selected and began processing Medicare Part B claims in Georgia on December 27.

Aetna has experienced start-up problems, as evidenced by a backlog of claims and other operational difficulties. Of course, this situation was clearly unacceptable and did not meet federal standards. I want to assure you that resolution of these problems is a high priority at Health and Human Services. Through our Regional Office in Atlanta, we are monitoring Aetna's work on a daily basis, and we have witnessed some remarkable improvement. Aetna has worked with our Department to help correct these problems.

While the situation remains serious, we believe that Aetna has gained control of their workload very quickly, and will continue to show improvement. For example, we believe that the start-up claims processing problems are well on the way to being resolved. As of May 1, the pending claims workload had been reduced to under 500,000 claims. That is still too high. But the pending caseload for the end of June will be 325,000 cases. Also, Aetna has increased its phone line capacity. Approximately 5 percent of calls in March have received a busy signal, down from a high of 60-90 percent during peak hours before the installation of the new lines. We have been assured that the phone problems will be ameliorated by the end of July. Accuracy is also increasing. Error rates are

coming down. Errors are a direct result of new staff. In response, Aetna has developed a strong action plan to identify errors in claims processing so that they can be corrected prior to payment of the claim. I have asked the Health Care Financing Administration to expedite their efforts to help Aetna get on track.

**W**e have also held discussions with many interested parties, in addition to the Medical Association of Georgia including the Durable Medical Equipment Association, the Georgia Medical Group Administrators, the ambulance suppliers, the Georgia Medical Society, the Georgia Society of Internal Medicine, and the Georgia Congressional Delegation.

In fact, the acting Health Care Financing Administrator, Lou Hayes, has personally met with Dr. Joe Bailey and many other physicians, congressmen, and interested parties to listen and learn. Based on their recommendations, federal law, the expertise of the Department, and the hard work of Aetna officials, Aetna has made measurable progress.

I fully expect Medicare claims processing in Georgia to return to normal next month. I might add that throughout this period, Aetna has continued to make Medicare payments into the state at a rate of over \$40 million per month since January — an average that is equal to, if not higher than, the average amount paid monthly by Prudential.

As physicians, you have responded with patience, caution, and prudence, with claims assignment increasing to nearly 80 percent. This is above the national average and demonstrates your willingness to stand by the national commitment made to our elderly.

**A**ll of this takes place at a critical time. For the last several years the federal government and many organizations, including the Medical Association of Georgia, have been fighting to lower the cost

of health care without diminishing quality. We all know that the high cost of health care is unacceptable. All of us have to work harder to cut costs without compromising quality. In calendar year 1987, health care cost the American people more than \$500 billion — 11 percent of our gross national product. And those costs are still going up. Some estimates are that American health care expenses will be over \$600 billion in 1989. Rising health care costs simply must be brought under control.

As costs increase, more people are squeezed out of the health care market. For example, more than 37 million Americans are not covered by health insurance, mostly because of the high cost of premiums. In addition, the more than 160 million Americans dependent on employer-sponsored health insurance plans are also threatened by rising costs.

The repercussions are obvious. These rising costs make it difficult to get health care insurance if you don't have it and tough to afford when you do. In fact, many companies have reacted to rising costs by cutting benefits and raising the proportion of employee contributions. Some companies have even instituted preemployment screening programs.

There is some evidence that up to 25 percent of what we spend for health care does not buy needed care nor provide an increased measure of quality.

**T**here are no easy answers to the problem of escalating health care costs, but the federal government has a responsibility to find measures for cost containment. The Prospective Payment System, implemented in 1983 with Diagnosis Related Groups (DRGs), demonstrated that costs could be better contained if the proper incentives were offered.

The success of Health Maintenance Organizations (HMOs) has also demonstrated that competition and case management help to restrain the rate of health care cost inflation. As a result of reforms in-



troduced during the past 8 years, over one million Medicare beneficiaries have chosen membership in HMOs.

Competition can help to preserve, and even enhance, the quality of care. Since 1983, a number of studies have shown that the quality of care in hospitals has not declined. A report in March, 1989, by the Prospective Payment Assessment Commission, an independent panel established by Congress, found that there is no evidence of "substantial or systematic changes in the quality of care received by Medicare hospitalized patients since the implementation of (the Prospective Payment System)." In this new world of competition, we must be very sensitive to any potential change in the quality of care. That is why I support further efforts to evaluate the quality of health care.

**I**n Georgia, such an effort is underway. At the same time that the transition from Prudential to Aetna was taking place, Healthcare

COMPARE began a medical review of Aetna's claims. Under a pilot test, Healthcare COMPARE is applying private sector utilization techniques to Medicare claims. I know that there has been some confusion. In an effort to increase understanding and cooperation, the Health Care Financing Administration has held several meetings with Aetna and Healthcare COMPARE officials.

As a result of these meetings, an AD HOC advisory committee made up of physicians and suppliers was established to bring concerns and problems of health care providers to the Attention of Aetna. Aetna has also issued a medical policy statement to the medical community. They have also pledged consultation with the physician community prior to any changes in review policy, and this is one point upon which I will be very insistent.

Also, Aetna has taken the extra step to develop claims or request additional information from you on comprehensive visits, concurrent

care, and initial consultations, prior to determining whether the claim is reasonable and necessary for Medicare payment. In my opinion, these steps will help all of us understand the system more clearly, and will foster a new spirit of cooperation.

The bottom line is this: all of us want to preserve the quality of care while fighting escalating health care costs. I am convinced that this will be done if we work together. During this period of transition, we have tried to listen to all sides, and I believe everyone involved has attempted to be open and frank. I know we can continue to have an open dialogue with each other. I am certain that together we can preserve the quality of care and restrain the rate of increase in health care costs.

Thank you for the invitation to share these thoughts with you today. I know you will have fruitful discussions during the next few days.

# Report

## Reference Committee



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**T**he following physicians were members of Reference Committee A: Dan B. Stephens, Chairman, Cobb; Albert A. Carr, Vice Chairman, Cobb; Roy W. Vandiver, DeKalb; Charles W. McDowell, Jr., DeKalb; Dent W. Purcell, Georgia Medical; Gerald E. Sanders, Cobb; Asa G. Yancey, Medical Association of Atlanta; and Anthony F. Isele, Dougherty.

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### IMMEDIATE PAST PRESIDENT

**Jack F. Menendez, M.D.,**

**T**his has been an eventful year for our Association. As we look into the future there are several concerns I wish to bring to your attention.

Last year the Association directed that the Immediate Past President direct legislative events. The Physician Involvement Program for the first time had a physician, experienced in the legislative process, who acted as a "shepherd" for the PIP volunteers who came to the Capitol for the day. The feedback I have received is that the helpful physician was appreciated by our PIP doctors. This year we ran the program Tuesdays, Wednesdays and Thursdays. We had plenty of volunteers on Wednesdays and Thursdays, almost none on Tuesdays. We should tailor the program accordingly.

A second concern I wish to address is an idea I heard at the AMA Leadership Conference. One of the

"bum raps" that our health care system constantly faces is "access." We are constantly told that there are millions of Americans who lack access to health care. At the conference, the Kentucky Medical Association reported on a plan they have had in place for several years which is their attempt to address this problem through a system of volunteers. Though this approach is not perfect, it is viable and has drawn favorable comments from the Kentucky State Legislature. The KMA presenter at the conference said he felt the KMA had received as much from the plan as the recipients. I urge our Association to study it and present an action plan to the fall Board meeting.

There has been an unprecedented turnover in top MAG personnel this year. As these firings and resignations have occurred, it has become abundantly clear that the Association needs to develop clear guidelines for Physician-Officer-Staff relations. This is a must if we are to continue to enjoy the trust placed in us by our members.

We have one of the best medical associations in the country. In order to maintain ourselves in this position, we have to continue to work





*Members of Reference Committee A (L to R): Roy W. Vandiver, Anthony F. Isele, Asa Yancey, and Dent W. Purcell.*

hard, be responsive to our changing medical environment, and be willing to address the tough issues.

#### **Recommendations**

1. That the PIP program be continued next year on Wednesdays and Thursdays. We should also continue to recruit physicians who are knowledgeable about the legislative process to direct the PIP volunteers on a day by day basis. *(Referred to Reference Committee C.)*

2. That MAG evaluate the plan in place in Kentucky to increase access to health care by our citizens. *(Referred to Reference Committee B.)*

3. That the Judicial Council develop clear policy guidelines governing Physician-Officer-Staff relations.

#### **HOUSE ACTION**

Referred Recommendation 3 to the Board of Directors.

## **FIRST VICE PRESIDENT**

**Richard W. Cohen, M.D.**  
**First Vice President**

### *On The Road Again...*

**I** have been your Vice President for the last two years, serving initially as your Second Vice President and for this past year as your First Vice President. It has been a rewarding, pleasant, and educational experience with no identifiable drawbacks. It has been a privilege to have served you as an officer in the Medical Association of Georgia.

I had approached my position as Vice President in a somewhat different manner than previous Vice Presidents. I had seen it as an opportunity to meet the physicians of the State of Georgia and to explore the towns, cities, and back waters. As Second Vice President, I visited eight medical societies from one corner of the state to another. As First Vice President, I visited more than twenty component societies and district societies in the State of

Georgia. I have been in small hamlets as Ft. Oglethorpe and Moultrie, and in metropolitan areas like Savannah, Augusta, and greater Atlanta.

Because of these travels, I have had the opportunity to meet the physicians from across the state and to discuss with them the issues of the day. Ultimately, I have come to appreciate the enormous physical size of the State of Georgia as well as the diversity of the physicians within the state and to realize that the physicians in metropolitan Atlanta see things very differently from the physicians in Ft. Oglethorpe, Moultrie, and Waycross. I now realize that the further one travels from the city of Atlanta, the more tenuous the relationship with MAG. In light of the size of the state of Georgia and the number of component societies within the state, there are many societies that have not seen an officer of MAG in five or more years. This is clearly a major problem for the leadership of MAG. It is most difficult to lead and to communicate if one is unable to come in direct physical contact with the leadership of the component societies in their home towns and counties. Without the presence of MAG





(L to R) Delegates Gerald Sanders and Albert Carr also served on Reference Committee A.

leadership on the local level, I do not believe that MAG's message can be heard. In addition, MAG leadership is unable to understand the local problems of the component societies without these visits.

### Recommendation

With the above as a preamble, I would like to suggest, and strongly recommend, that our leadership visit each component medical society yearly.

I believe that if this recommendation were to be followed, we would significantly increase our communication and understanding within the leadership and members of our component societies, thus substantially increasing and strengthening our state-wide organization.

I would like to thank you again for the opportunity of having been your Vice President for two years. It has taught me a lot, introduced me to many and has, in the end, brought great rewards and satisfaction.

### HOUSE ACTION

Adopted as amended: "That the MAG strongly recommends that our leadership visit each component medical society and each specialty society every year upon request."

## MEDICINE & HUMAN VALUES COMMITTEE

**Richard B. Stewart, M.D.,  
Chairman**

### Recommendation

It is recommended that this Committee be abolished. If the membership wishes specific ethical issues to be addressed, it would seem appropriate to appoint ad hoc committees of physicians knowledgeable

about the particular issues to develop a proposed position statement or other recommended actions for the Association.

### HOUSE ACTION

Adopted.

## NON-PHYSICIAN HEALTH CARE PROVIDERS COMMITTEE

**Richard W. Cohen, M.D.,  
Chairman**

The major issue that was closely followed by the Non-physician Health Care Providers Committee this year was that of nurse prescribing and dispensing drugs. The Attorney General issued a ruling in May 1988, that declared that nurses using protocols could not legally prescribe or dispense medications, as was being done in health departments and several other settings in the state. The Committee applauded the ruling, noting that the Medical Association of Georgia's position has always been that the law did not support some existing nursing practices.

The Committee recognized that county health departments needed some type of legislative help, but insisted that the Medical Association of Georgia continue to emphasize quality care, and to insist that DHR and the General Assembly recognize that those acts by nurses that are done under protocol are medical acts and must be regulated by the Composite State Board of Medical Examiners.

The nurses saw the Attorney General's ruling as a window of opportunity — a chance to revamp and expand the Nurse Practice Act into the medical arena. After numerous meetings between MAG and a representative group of nurses, the



nurses decided to break their agreements with MAG and seek broad medical authority in the legislature.

In the end, however, medicine prevailed, and control over nursing protocols was appropriately placed in the Composite Board of Medical Examiners. Not only did the law stipulate that there be physician control over the acts performed under protocol by nurses, but for the first time in state law, physicians will set drug dispensing procedures for nurses equally with pharmacists. This expansion of the physician authority over nurses into the dispensing arena should be applauded by all physicians.

The physical therapists once again sought to practice independently from physicians. The Chair of this Committee appeared before the Home Health and Ecology Subcommittee studying the issue and testified in behalf of physician control over physical therapy. The full committee agree that there was not enough evidence to make changes and refused to vote on the bill.

The Non-Physician Health Care Providers Committee continued to monitor the activities of other health care providers, and was pleased that the other providers decided not to attempt major practice expansions in 1989.

## Recommendation

1. The Committee continue to monitor activities of other health provider groups.

2. The Committee be utilized as the clearinghouse for proposed rules and regulations of non-physician health care provider boards that are substantive in nature. All negative proposals should be referred to staff by the Committee in order to present MAG's opposition in an appropriate manner.

3. The Joint Practice Committee, which serves as a subcommittee of the Non-Physicians Health Care Providers Committee, should be abolished. The full committee has

sufficient expertise to examine the role of the nurse.

## HOUSE ACTION

Adopted.

### RESOLUTION 17 Unified Membership With the AMA Larry Brightwell, M.D.

*Whereas*, several state medical associations have adopted unified membership with the American Medical Association, requiring all members of the state association to become members of the AMA as well; and

*Whereas*, unified membership results in both an increased commission for the state society collecting dues, plus a 10% AMA dues reduction for members; and

*Whereas*, the experience of the Mississippi State Medical Society shows that unified membership may result in an increase of membership for the state as well as AMA; therefore be it,

RESOLVED, that the Medical Association of Georgia amend its membership policies to provide for unification of medical society membership at the AMA, MAG, and component county society levels.

## HOUSE ACTION

Did not adopt.

### RESOLUTION 24 Organizational Evaluation Medical Association of Atlanta

*Whereas*, the Medical Association of Georgia plans to employ a

new chief staff executive, i.e. Executive Director, to manage the affairs of the Association; and

*Whereas*, it would be very timely and beneficial to conduct an organizational evaluation of the Association to coincide with this change in management; and

*Whereas*, the American Society of Association Executives (ASAE) and the American Association of Medical Society Executives (AAMSE) provide evaluation services that measure both the short-term and long range strengths and weaknesses of an organization; therefore, be it

RESOLVED, that the Medical Association of Georgia allocate the necessary funding (approximately \$7500) for an organizational evaluation; and be it further

RESOLVED, that the Medical Association of Georgia conduct an organizational evaluation of the Association and utilize the services of ASAE, AAMSE or other appropriate body with association management expertise.

## HOUSE ACTION

Referred to the Board of Directors.

### RESOLUTION 33 MAG Roster Charles R. Underwood, M.D.

*Whereas*, the "directory" of the MAG currently lists the name of physician members of the organization, their office address, their county number, their membership status (active, etc.) and their specialty, and

*Whereas*, further information pertaining to physician members of the MAG would be of increased benefit making the "directory" more useful, and



Dan B. Stephens, Chairman of Reference Committee A, gives his committee's report to the House.

*Whereas*, the present "directory" has not been utilized in the past as an advertising income vehicle, therefore, be it

RESOLVED, that the MAG directory in the future also list each physician member of the organization, their office address and telephone number, home address and telephone number, and hospital affiliation, in addition to the above information, and be it further

RESOLVED, that increased effort be expended to generate advertis-

ing for the directory as a means of making the publication financially self sustaining.

### HOUSE ACTION

Adopted each of the RESOLVED portions of the Resolution and added the following:

RESOLVED, that this directory be distributed only to MAG members and staff.

## RESOLUTION 35

### AEtna Lawsuit

E. M. Molnar, M.D.

*Whereas*, AEtna Casualty & Surety Company has failed and is continuing to fail to perform the service of Medicare intermediary in the State of Georgia in an appropriate and satisfactory manner; and

*Whereas*, these failures to properly perform include, but are not limited to, inadequate facilities for managing claims volume, undue delay in claims response, failure to adequately communicate with providers, arbitrary denial of claims without sufficient justification, arbitrary down coding of claims without adequate justification, and inappropriate use of "unnecessary service" denial; and

*Whereas*, these failures have created undue demand on physician officer personnel, undue aggravation for physician providers, severe delays in payment or failure altogether of payment of Medicare claims and financial hardship on some physician providers; and

*Whereas*, these same failures create delays, reduction and denials of reimbursement of Medicare recipients for non-assigned health care expenditures, creating undue hardships on these patients; now, therefore be it

RESOLVED, that the Board of Directors of the Medical Association of Georgia immediately investigate the appropriateness and be authorized to file a federal class action suit or other legal action on behalf of MAG's members and their Medicare patients to require HCFA and/or AEtna to:

1. Immediately provide adequate and appropriate fiscal intermediary services for Medicare recipients and providers;

2. Halt, cease and desist inappropriate, arbitrary and/or capricious actions;

3. Reimburse physicians and recipients for additional costs and interest in submitting or resubmitting Medicare claims that were inappropriately delayed or denied; and

4. That appropriate relief be sought including, where appropriate, both actual and punitive damages.

### HOUSE ACTION

Adopted as amended:

"RESOLVED, that the Board of Directors of the Medical Association of Georgia immediately investigate the appropriateness and be authorized to file a federal class action suit or take other appropriate legal action on behalf of MAG's members and their Medicare patients to resolve the problems with HCFA, AETNA, and/or Health Care COM-PARE."



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# Report Reference Committee

# B

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## IMMEDIATE PAST PRESIDENT

**Jack F. Menendez, M.D.**

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**R**eference Committee B was comprised of the following physicians: Hugh S. Thompson, Jr., Chairman, Medical Association of Atlanta; O. Wytch Stubbs, Jr., Vice Chairman, DeKalb; Dolford F. Payne, Jr., Medical Association of Atlanta; Virgle W. McEver, III, Peach-belt; Robert Glenn Carter, St. Johns Parish; William Wolff, Muscogee; Alfred L. Davis, Jr., Ware; and John Antalis, Whitfield-Murray.

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**R**efer to the Report of Reference Committee A for the full report of the Immediate Past President.

### Recommendations

1. That the PIP program be continued next year on Wednesdays and Thursdays. We should also continue to recruit physicians who are knowledgeable about the legislative process to direct the PIP volunteers on a day by day basis. (Referred to Reference Committee C.)

2. That MAG evaluate the plan in place in Kentucky to increase access to health care by our citizens.

3. That the Judicial Council develop clear policy guidelines governing Physician-Officer-Staff relations. (Referred to Reference Committee A.)

### HOUSE ACTION

Adopted Recommendation 2 as amended: "That the MAG President appoint a Committee to evaluate and consider a plan, comparable to

that of the Kentucky Medical Association, to increase access to health care by our citizens. This plan should be available for consideration by the September, 1989 meeting of the MAG Board of Directors."

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## MEDICAL PRACTICE COMMITTEE

**Rodney L. Smith, M.D.,  
Chairman**

**T**he Medical Practice Committee submits the following report to the MAG House of Delegates for its information and consideration.

### The RBRVS

During 1988-89 emphasis was given to the review of national developments concerning Harvard University's "National Study of Resource-Based Relative Value Scales for Physicians Services (RBRVS)." Interest was both in the content of the Phase I report findings as well as how those findings are accepted by policy makers, the medical profession, payers and the public.





*Members of Reference Committee B (L to R): Alfred L. Davis, Jr., William Wolff, Dolford F. Payne, Virgle W. McEver, III, Robert Glenn Carter, and John Antalis.*

The Committee felt there was a pressing need for Georgia physicians to become more informed about the methodology and objectives of the RBRVS and to voice their opinions on those aspects which are felt to be in the best interest of all parties.

In the Committee's opinion, this next year will be a period of intensive evaluation and public discussion of the RBRVS. The Physician Payment Review Commission will be offering its preliminary findings and recommendations to Congress on implementation of a fee schedule based on the RBRVS in addition to the Department of Health and Human Services' evaluation and recommendations in July 1989 for a possible January 1, 1990 or 1991 implementation date.

It is the Committee's studied opinion that the Association should lend cautious support only to the study at this time and continue a rigorous scrutiny of its development in 1989. Issues requiring particular attention are: a.) How the relative value scales will be converted to financial factors and at what levels they will be applied; b.) Specialty differentials; c.) Geo-

graphic variations; d.) Coding changes; e.) Physician assignment; and f.) Updating the "Value Scale." Physicians are asked to express their comments to colleagues, Association representatives, and Congressional members.

#### **The Health Policy Agenda for the American People (HPA)**

In 1988, the Committee also continued its liaison role with the AMA's HPA Implementation Committee. In February, 1987, the HPA issued its Final Report containing 195 policy recommendations encompassing all major areas of health care. This year the HPA has been overseeing efforts to carry out specific recommendations. Following a September 1988 progress update, the HPA sent the Medical Association of Georgia in February, 1989, a copy of the Final report of the Health Policy Agenda Ad Hoc Committee on Medicaid, "Including the Poor," and a press kit to publicize their recommendations. The recommendations — advocating that Medicaid be governed by uniform national standards for eligibility, benefits, and reimbursements — are now under review by our Committee.

#### **Home Health Services**

Another ongoing interest of MAG's Medical Practice Committee has been the physician's continued tenuous case management responsibilities for patient home health services. Following the 1988 MAG House of Delegates supportive action, the Committee put forth a request to the U.S. Health Care Financing Administration that physician services related to home health care be formally recognized and, as such, included as a separate reimbursement category under Medicare. In Georgia, home health care services represented care to over 55,000 patients in 1986 alone. A train of AMA House Reports through 1988 contain in depth discussions on this subject and conclude that several CPT code definitions are pertinent for addressing these administrative case management responsibilities.

Also studied with interest were the Georgia Medical Care Foundation's progress in meeting new federal guidelines requiring quality reviews of home health care services. Members were briefed on administrative review screens which



would be used beginning in April 1989.

### **Alzheimers Disease Education and Other Legislative Concerns**

Finally, during 1988-89, the Committee lended support to the Alzheimers Disease Association's educational efforts focused at physicians in aging-related specialty areas. Educational materials about Alzheimer related resources and referrals were sponsored in a physician mailing and through *MAG Journal* articles.

The Committee concluded its work with review and briefings on pertinent legislation which might have special impact on medi Bill, HB. 209, and Informed Consent.

We share the concern of physicians across the state over our legislature's power to affect our practices. Rather than balk at this governmental influence in medicine, we would like to capitalize upon it as a means of helping to shape ideas and a general vision about medical care delivery in Georgia. Specifically, we have in mind calling upon the MAG to provide more forums for groups of legislators and groups of concerned physicians to exchange views on the health care needs of our fellow Georgians. The present Legislative Seminar, limited to a few leaders of each specialty, we feel, may be inadequate as a loosely structured forum to discuss medico-legislative health priorities for the people of Georgia. Perhaps MAG could help or organize a series of medico-legislative meetings, well advertised and open to all MAG members with an invited list of state representatives or senators, which could be held during quarterly MAG Board meetings, especially as those meetings are now being held around the State.

### **Recommendations**

1. That the Medical Association of Georgia give cautious support

only to the "National Study of Resource-Based Relative Value Scales for Physician Services" and that the Association conduct, through this Committee or any other appropriate Committee they may determine, a full evaluation of the study by all affected parties. Further, the Committee recommends that the Association not give full support to the AMA/Harvard relative value study until the concerns of all physicians are appropriately addressed.

2. That the Medical Association of Georgia consider developing a series of medico-legislative "town meetings," open to MAG members, structured to provide physicians and invited legislators with loosely structured forums to discuss common approaches to meeting the health care needs of our fellow Georgians. (*Referred to Reference Committee C.*)

### **HOUSE ACTION**

Adopted Recommendation 1 as amended: "That the Medical Association of Georgia continue to evaluate the "National Study of Resource-Based Relative Value Scales for Physician Services."

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## **PUBLIC HEALTH COMMITTEE**

**Grey Rawls, M.D.,  
Chairman**

**D**uring 1988-89, the MAG Public Health Committees' activities largely focused on the preparation and publication of "A Clinician's Guide to AIDS and HIV Infection in Georgia." The document was prepared as a reference guide on AIDS for physicians, nurses and other medical personnel. The Committee, in consultation with a special AIDS review panel and the MAG Ad Hoc Committee on AIDS, spent several months preparing and review-

ing various drafts. Information was included on diagnosis and counseling, the natural history of infection, testing, legal and reporting requirements, etc. In November, over 12,000 copies of the final publication were sent to actively practicing physicians in Georgia. Due to the strong response, an additional printing of the booklet was made in November, which was also distributed. The Centers for Disease Control, the Center for Prevention Services, the AMA Office of AIDS/HIV and many other national and state societies were highly complimentary of the work and are sharing it with other states, "as an example to emulate," in the words of the CDC Director.

A second focus of Committee interest-adolescent health-combined well with the AMA's national initiative on adolescent health and the Association's healthy lifestyle campaign. The MAG Teen Health Risk Appraisal Program — a quick turnaround, computerized program for assessing teenage health risks — was greatly improved and updated this year with relevant questions added on drugs and driving. The Association purchased computer discs and program packages which were distributed to all 186 school systems in Georgia. Further, through the cooperation of the DHR Office of Human Resource Development and the Department of Education, training sessions were provided on the "risk" program to 16 Regional Educational Service Agencies throughout the state during January and February, 1989. The efforts were an attempt to again encourage greater interest in healthy lifestyles among schools and adolescents. The Committee was also very pleased to offer the Teen Health test as a part of the MAG Auxiliary "It's Up to Youth — Teen Health Forum" in Athens in March of this year.

The Committee also continued their efforts to further promote and endorse the Adolescent Urine Drug Screening program as mandated by the 1988 MAG House of Delegates.



A MAG news release was issued in September, 1988, communicating the program's endorsement by the Georgia Congress of Parents and Teachers and the Council for Children. During 1988, the Georgia Legislature passed a bill encouraging local public health departments to make the drug testing available to families on the sliding fee scale. Immunity from liability was also legislated for physicians participating in such programs in the absence of gross negligence.

Finally, the Committee continued their review and comments on a variety of public health policies and regulations proposed for the state including (a) regulations on Solid Waste Management, Anatomical Gifts, and Immunization of Children as a Prerequisite to Admission to Schools; (b) AIDS education and testing; and (C) Federal OBRA laws related to nursing home admissions.

As Chairman, I would like to commend the members of our Committee for their help and enthusiasm in the past year's activities. They are: Sam O. Atkins, Philip N. Bannister, William R. Elsea, Harold P. Katner, A. A. McNeill, Jr., S. Charlotte Neuberg, Elton S. Osborne, Jr., Wells Riley, Mrs. Roy W. (Maureen) Vandiver.

I wish to give particular notice to the loss of Dr. Gunar N. Bohan, M.D., who was a very enthusiastic and interested member of the Committee during the past few years. Also, I would like to again acknowledge the special work of the AIDS Advisory Panel who contributed much of their personal time in very carefully preparing, reviewing, and editing various sections of the "Clinicians Guide on AIDS and HIV Infection in Georgia."

### Recommendation

1. That the Public Health Committee continue their review of proposed state regulations for solid waste management issued by the Georgia Department of Natural Re-

sources — considering what effect they represent for physician medical practice settings — and make appropriate comments for response.

### HOUSE ACTION

Adopted.

## SENIOR CITIZENS ADVOCACY COMMITTEE

**Joe L. Nettles, M.D.,  
Chairman**

**T**he Medical Association of Georgia House of Delegates in its April 1988 meeting voted to "most expeditiously" develop a "Senior Citizen Advocacy Program." The House did not specify what type of advocacy program should be developed or whether it should be implemented statewide or operated initially as a pilot program.

A committee was appointed and charged to examine various programs that have been established by state medical associations that serve the elderly, especially low-income elderly citizens, and to plan, develop, and implement a senior citizen advocacy program in Georgia.

There appear to be three main types of senior citizen programs that have been implemented by medical societies across the United States. The first type is an informational program, such as a toll-free hotline, which provides information to senior citizens and those who work with them about medical and non-medical services available in the area. The second type is a program of free care for senior citizens under a certain income limit, established and coordinated by a local medical society. The third, and most popular, type is a program where the

medical society takes the lead in encouraging physicians to accept Medicare assignment for elderly citizens whose income is under a certain amount.

The committee considered the feasibility of establishing voluntary Medicare assignment through pilot programs in county medical societies. Efforts to start a program to encourage physicians to accept Medicare assignment for the elderly poor in Hall County were not successful. Most physicians were reluctant to accept assignment. Some because of increasing resentment against the system and the discriminatory limitations it has placed on physicians; others because of the concern that accepting assignment would decrease their time to treat enough other patients to make a living. Too many barely break even with Medicare patients, i.e., payments don't meet the cost of providing the care.

The local Department of Family and Children Services was willing to cooperate with the program and could administer the same means test and issue the same ID cards that are used in the DHR clinics, but they had no money to hire the extra personnel to provide this service.

Considering the current problems with the Medicare program in Georgia, it was decided that further efforts along this line would be postponed at this time.

Access to medical care is a major concern of both the MAG and Medicare beneficiaries. The MAG has a long-standing policy that no patient in Georgia should be denied medical care because of inability to pay.

Regardless of the extent of their frustration with whatever unreasonable payment mechanism we may be dealing with at the time, we know that physicians will continue to see their regular patients and accept new patients as they present, in accordance with the physician's routine mode of practice. Elderly patients may not understand this and may be frightened if physicians ex-



press their frustrations in a manner that indicates the physician may be reluctant to continue to see them.

The current fiasco with the change of the Medicare carrier in Georgia coupled with the addition of a pilot utilization review project presents a unique opportunity for physicians and patients to unite in their efforts to deal with the whole gamut of Medicare problems. Since physicians' offices are usually more capable of dealing with denials, reductions, erroneous payments, etc., than patients, physicians may wish to consider accepting assignment, particularly in complicated cases, or assisting patients in completing forms for reimbursement. Physicians should at least let the patient know that they may encounter problems and that they are willing to help them deal with the system.

The committee heard presentations from William C. Waters, M.D., Chairman, MAG Committee on Medical Schools, and Jeffrey T. Nugent, M.D., Chairman, MAG Public Relations Committee about the need for education of Georgia physicians and senior citizens about problems associated with Medicare. Dr. Waters discussed the Medicare program from the perspective of its evolution from a government's promise to provide medical care for the elderly to its current restrictive nature which actually limits the patient's right to purchase what the government now refuses to provide.

Cost containment measures have limited amounts that can be charged for service, limited amounts patients can pay, declares a large variety of medical services including nearly all preventive services "Medically unnecessary" and therefore not purchasable unless patients sign an affidavit to pay before the service is provided, established DRG's and other utilization controls which effectively ration care, etc. Very few physicians and/or patients realize the effect of these efforts has been to disenfranchise the Medicare

beneficiary's right to purchase medical care. No payment is authorized for anything other than what the government says is OK and that changes with every budget.

If this limitation were placed on any other service, class action suits would be filed from every quarter. Instead, we have advocacy groups supporting government action.

Most persons over 65 are able to pay for a portion of their medical care. A December 1988 publication of issues facing Georgia published by the University of Georgia, *Georgia's Changing Social, Economic and Demographic Environment: A Historical Perspective* by Douglas C. Bachtel, Marylou Mandell and Everett S. Lee indicates that 14.2% of person 65 and over are living below the poverty level 1979 — compared to 16.6% of the general population and 35.5% of female-headed households. The majority of persons over 65 living below the poverty level reside in north Georgia while the majority of others living below the poverty level are in south Georgia.

A Georgia Department of Human Resources Task Force Report (December 1987) indicates that, commensurate with the national picture, Georgia's population is rapidly aging. While the average population is expected to increase by more than 40% by 2000, the age 65 group will increase at twice that rate and the over 80 group will increase at 140% (most will be female). This same report stated Georgia's 65+ population as 572,177.

Currently, less than one-third of Georgia's physicians are "Participating Providers"; however, 70-80% of the claims for services are filed on assignment basis. In response to the 1986 physician survey conducted by the Composite State Board of Medical Examiners, 83% of Georgia physicians indicated they accepted Medicare patients. Considering the number of physicians who would not usually see Medicare patients in their usual practice,

i.e., pediatricians and academic physicians, this high percentage reflects Georgia physicians' concern about their elderly patients.

The committee will pursue the feasibility of establishing a program of free care for the elderly who "fall through the cracks" of Medicare/Medicaid. There may also be some merit in implementation of voluntary assignment programs in the future. However, the committee feels that the greatest need at this time is for an education program to help patients understand what is happening to them under the Medicare program and how to deal with their day-to-day problems with doctors and insurance carriers, including Medicare.

Toward this end, the committee reviewed PROJECT TIP (To Inform the Public) as presented by Dr. Nugent. This is a series of activities designed to inform physicians and the public about these issues. The committee also reviewed a number of publications and brochures developed by other agencies.

### Recommendations

After further discussion, the Committee agreed to recommend that:

1. MAG urge physicians to continue to see Medicare patients and help them deal with current or ongoing problems with Medicare.

2. MAG educate physicians and senior citizens about changes in the Medicare program and the potential impact of these changes on the physician and the beneficiary. (*Referred to Reference Committee D.*)

- \*3. A patient information brochure developed by the Indiana Medical Association, entitled "Medicare: What You Should Know," be revised for distribution in Georgia. (*Referred to Reference Committee F.*)

- \*4. An easily revised fact sheet regarding Medicare be prepared. (*Referred to Reference Committee F.*)



\*5. A hotline for Medicare patients be established in MAG headquarters on a one-year trial basis. (*Referred to Reference Committee F.*)

6. MAG pursue the feasibility of developing voluntary medical care and/or Medicare participation programs for those senior citizens living at or below 150% of the Georgia poverty level. (*Referred to Reference Committee F.*)

7. Representatives of the AARP and other appropriate agencies be invited to participate in the development of the education process. (*Referred to Reference Committee D.*)

\*Fiscal Note: Funds included in Public Relations Committee Budget.

## HOUSE ACTION

Adopted Recommendation 1.

## THIRD PARTY PAYORS COMMITTEE

**C. Peter Lampros, M.D.,  
Chairman**

Efforts to control health care costs, especially costs related to Medicare, and concerns regarding quality review, utilization and professional liability have all contributed to continuing rapid change in the medical practice environment, especially reimbursement systems. The Third Party Payors Committee, in response to these changes, carefully considered many of these subjects of importance to medicine during 1988-1989 and presents the following summary:

### Physicians Involvement with Medicare

With the continuing high rates of growth in medicare expenditures, increased restrictions are being imposed on payments for physicians.

The Omnibus Budget Reconciliation Act of 1987 was enacted on December 22, 1987 and produced a number of physician payment changes for both fiscal year 1988 and fiscal year 1989, including:

- increasing the Medicare Economic Index;
- reduction of the prevailing charge levels for 12 so-called "over-priced" procedures;
- development of a relative value guide for anesthesia services and an RVS fee schedule for radiologist services.

Implementation of the Medically unnecessary provision of the 1986 OBRA Act also continues to pose difficult problems for many Georgia physicians.

In addition, on January 1, 1989, Georgia was assigned a new Medicare Intermediary, The Aetna Life Insurance Company of Savannah, Georgia. The conversion activities associated with this change in carriers resulted in a very disruptive payment process in 1989 in which errors were flagrant and payments became tremendously backlogged and delayed. To address many of these concerns and in keeping with the MAG House mandate of 1988, the Third Party Payors Committee took several steps to keep Georgia physicians better informed and assist them in their negotiations with the Medicare carrier.

Medicare news updates were provided throughout the year through a series of direct mailings, Association newsletter reports, and through the continued scheduling of Medicare Law Update Seminars. The MAG Medicare Seminars, held in November and December, 1988 were attended by over 1600 physicians and their office staffs in eight locations throughout the state.

To address some of the serious problems of the Aetna conversion, MAG leadership had a series of ongoing meetings with representatives of Aetna, HealthCare Compare, the Region IV HealthCare

Financing Administration and Georgia Congressional Staff.

The Committee met with the Chairman of the HealthCare Compare Corporation to discuss the new utilization review controls put into effect and other general matters of concern to physicians. The Association also maintained a "Medicare Hotline" to assist physicians with their more pressing problems during conversion.

### Prior Authorization and Utilization Review Guidelines

In carrying through with the previous year's activities and in response to several MAG House mandates, i.e. Resolutions 19 and 21, the Committee continued their study of prior authorization and other utilization review programs and their effect on physician practices. In September, 1988 a utilization review (UR) survey, was conducted of some 20 UR and insurance companies most prominent in the state. The survey collected information on reviewer credentials, utilization criteria, patient identification and medical information required, physicians consultation, penalties, etc. The data was to be used to assess consistency in UR systems, possible problem areas, and to form the basis for developing appropriate guidelines for their use. Coincidentally, the Association was contacted by Georgia's Insurance Commissioner, Warren Evans, concerning physicians' complaints he had received on the matter and with the request that an Association study be conducted and recommendations offered to him.

In November, the Committee prepared a set of draft guidelines for conduct of prior authorization programs and claims submission review, and appeals procedures. The guidelines offer an initial framework to encourage greater consistency in the structure and operation of prior authorization programs, and to assure the programs are implemented efficiently in conjunction



with medical care services. They were later approved by the MAG Executive Committee as the basis of discussion with Commissioner Evans.

Subsequently, meetings were held with Commissioner Evans who has agreed to convene with MAG a committee of industry representatives to iron out many of the UR problems.

### Recommendations

1. That the Association continue to rigorously oppose Medicare laws and regulations which work to the detriment of good patient-physician relations and services. (*Referred to Reference Committee C.*)

2. That the MAG work aggressively with the Georgia insurance commissioner, the insurance industry, and other payors to improve the administration of prior authorization and other utilization review programs.

### HOUSE ACTION

Adopted Recommendation 2.

## RESOLUTION 12

### Third Party Payor Claims Processing

**James Q. Whitaker, M.D.**

*Whereas*, health insurance companies frequently do not notify the physician if a claim is to be denied or if the patient is not covered; and

*Whereas*, this failure to notify physicians of denied claims may lead to months of delay, during which time the physician may lose the opportunity to bill the patient for his or her charges; therefore be it

RESOLVED, that the MAG cooperate with third party payors to improve their reporting to physicians and patients on claims processed

or denied, assuring physicians of timely notification regarding any and all claims not to be paid.

### HOUSE ACTION

Adopted as amended: "RESOLVED, that the MAG cooperate with third party payors to improve their reporting to physicians and patients on claims processed or denied, assuring physicians of timely notification regarding any and all denied claims."

## RESOLUTION 18

### Fiscal Solvency of Insurance Companies

**Larry Brightwell, M.D.**

*Whereas*, insurance companies possess millions of dollars of reserve funds which they invest for income; and

*Whereas*, bad investments can lead to loss of revenue for such companies, which they then must pass on to their policyholders as premium increases; and

*Whereas*, there may be insufficient governmental regulations in place to monitor insurance companies' investment or fiscal practices and to prevent substantial investment losses; therefore be it

RESOLVED, that the MAG investigate the need for stronger regulations by the State Commissioner of Insurance and if necessary make recommendations to insure the fiscal solvency of insurance companies in Georgia.

### HOUSE ACTION

Did not adopt.

## RESOLUTION 20

### Voluntary Acceptance of Medicare Assignment

**Dolford F. Payne, Jr., M.D.**

*Whereas*, in December 1987, the AMA adopted a resolution to "aid and encourage individual medical societies to develop voluntary Medicare assignment programs which will assist in the protection of the financial resources of the elderly of limited means and ensure access to health care for all the elderly"; and

*Whereas*, since that action twenty-two (22) medical societies across the country have implemented voluntary acceptance of Medicare assignment programs and nineteen (19) other medical societies are considering such programs; and

*Whereas*, successful voluntary programs could very well offset the need for mandatory Medicare assignment legislation which has been introduced in some twenty (20) states and enacted in four (4); and

*Whereas*, this House of Delegates adopted a resolution in April 1988 "that a Senior Citizen Advocacy Program be most expeditiously developed"; therefore, be it

RESOLVED, that the members of the Medical Association of Georgia (MAG) participate in a voluntary acceptance of Medicare assignment program for all patients, 65 years or older, with annual incomes at or less than 150 percent of the federally-determined poverty level; and be it further

RESOLVED, that the program be conducted at the local level by component societies with the support and administrative assistance of MAG.

### HOUSE ACTION

Adopted the first RESOLVED as amended: "RESOLVED, *that while*



most members already comply, that all members of The Medical Association of Georgia (MAG) participate in voluntary acceptance of The Medicare Assignment Program for all patients who are deemed medically indigent and who may otherwise be deemed eligible by the physician and that the matter be referred to the MAG Board of Directors."

Did not adopt second RESOLVE.

## RESOLUTION 26

### National Health Insurance

William E. May, M.D.

*Whereas*, a significant number of American Citizens are not covered by Medicaid, Medicare, or private health insurance; and

*Whereas*, the health care needs of this population are not being met by present delivery systems or providers' charity service; and

*Whereas*, most American voters now favor a public health care system based on British or Canadian models, despite the inefficiency and uncertain quality of care offered by such systems; and

*Whereas*, the individual's freedom of choice inherent in our nation's health care systems must be preserved, in order to foster initiative and progress, and to be consistent with our nation's fundamental social and political beliefs; therefore, be it

RESOLVED, that the Medical Association of Georgia House of Delegates adopt a formal position of support for a National Health Insurance system, with the following provisions:

— that all American citizens be required to maintain health insurance;

— that the Medicare, Medicaid and Veterans Administration programs be merged into a unified National Health Service, extending coverage to all citizens not covered by other insurance plans;

— that standards of minimum and maximum services, and of compensation to providers, be established and maintained within the National Health Service based on balanced input of the government, providers, and beneficiaries;

— that our present, privately-funded system of care be also continued for patients economically able and desiring to participate;

— that in such private system, minimum and maximum service standards, fees and compensations, be regulated by free market forces and traditional professional or ethical standards; and

— that professional providers, institutions, and facilities be allowed to function wholly within one or the other system, or to participate in both; and be it further

RESOLVED, that the Georgia Delegation to the AMA submit this resolution to the American Medical Association House of Delegates.

### HOUSE ACTION

Adopted substitute resolution in lieu of this resolution: "RESOLVED, that the MAG House of Delegates appoint a strategic planning Committee to work with the Georgia State Legislature to study the funding of care for medically indigent patients; and

BE IT FURTHER RESOLVED, that the AMA be urged to work with Congress to develop a similar strategic planning Committee nationally."

## RESOLUTION 45

### Investigation of Hospital Practices

Cobb County Medical Society

*Whereas*, hospitals are now under added financial pressures due to increasingly more restrictive reimbursement procedures; and

*Whereas*, some hospitals are apparently attempting to compensate for hospital revenue shortfalls by entering areas that are traditionally under the auspices of private medical care; and

*Whereas*, physicians' legal, ethical and social constraints have been professionally defined and different than those of hospitals; and

*Whereas*, the services above are advertised and rendered by hospitals and include hospital owned urgent care and primary care delivery clinics, sports medicine clinics, and women's services clinics; therefore, be it

RESOLVED, that the Medical Association of Georgia investigate the legal, ethical, and social structure of such hospital practices; and be it further

RESOLVED, that the Medical Association of Georgia urge the Composite State Board of Medical Examiners to investigate the management aspects of such practices and how they impact on the legal and ethical delivery of physician services in those units.

### HOUSE ACTION

Referred to the Board of Directors for further study and implementation as it deems appropriate.

## RESOLUTION 46

### Medicare Regulations

#### DeKalb Medical Society

*Whereas*, the regulations for Medicare as promulgated by the Health Care Financing Administration, and implemented by the PRO of Georgia prohibit a patient from obtaining a pre-certification authorization number and mandate that the physician, whether participating or non-participating, must obtain this authorization; and

*Whereas*, many non-participating physicians feel that obtaining authorization is the patient's responsibility since Medicare's relationship is with the patient and not the non-participating physician; therefore be it

RESOLVED, that MAG petition the Health Care Financing Administration to change the regulations to allow patients the option to obtain their own pre-certification authorization number and be it further

RESOLVED, that this issue be carried to the AMA House of Delegates and the Georgia Congressional delegation for assistance.

#### HOUSE ACTION

Adopted.

## RESOLUTION 48

### Medicare Program

#### Georgia Medical Society

*Whereas*, Aetna Casualty & Surety Company is now the Medicare carrier for Georgia; and

*Whereas*, HCFA has contracted with HealthCare COMPARE to provide peer review for Aetna; and

*Whereas*, the policies of HealthCare Compare and Aetna have been presented to practitioners of medicine in Georgia; and

*Whereas*, these policies both explicitly and implicitly alter time tested Doctor-Patient and Doctor-Doctor relationships and impair the mission of the physician to his patient; and

*Whereas*, current Aetna and HealthCare COMPARE policies actively imply that physicians are dishonest and medical care overpriced; and

*Whereas*, Aetna and HCFA have altered established agreements and operating practices since January 1, 1989, and inordinately delayed and reduced legitimate payments to physicians; and

*Whereas*, these policies are creating an intolerable paper trail for the medical profession and destroying confidence and trust in the Doctor-Patient relationship; and

*Whereas*, physicians remain dedicated to their patients and are their patients' only knowledgeable ad-

vocates in medical matters; therefore; be it

RESOLVED, that the MAG demand that HCFA and Congress require Aetna and HealthCare COMPARE to act in a responsible manner to maintain access of the Medicare patient to the health care system, and to the physician of his/her choice, and desist from arbitrary policies which result in disruption of the manner in which Doctor-Patient and Doctor-Doctor relationships have evolved and now exist to maintain excellent health care in Georgia and the United States.

#### HOUSE ACTION

Adopted as amended: "RESOLVED, that the MAG continue to encourage HCFA and Congress to require Aetna and HealthCare COMPARE to act in a responsible manner to maintain access of the Medicare patient to the health care system, and to the physician of his/her choice. Further, that Aetna also be required to cease and desist from arbitrary policies, (i.e., the down-coding of medical services and the requirement for automatic documentation of comprehensive services, initial consultation, and concurrent care) which result in disruption of the manner in which Doctor-Patient and Doctor-Doctor relationships have evolved and now exist to maintain excellent health care in Georgia and the United States.



# AXID®

## nizatidine

### Enhances compliance and convenience

**Patients appreciate Axid, 300 mg, in the Convenience Pak**

**In a Convenience Pak survey (N = 100)<sup>1</sup>**

- 100% said the directions on the Convenience Pak were clear and easy to understand
- 93% reported not missing any doses

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- The Convenience Pak saves dispensing time and minimizes handling

**The Convenience Pak promotes patient counseling**

- Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction



**Convenience Pak is available at no extra cost**

**Lilly**

Eli Lilly and Company  
Indianapolis, Indiana  
46285

**AXID®**

nizatidine capsules

#### Brief Summary

Consult the package literature for complete information.

**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg b.i.d. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests** — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

**Drug Interactions** — No interactions have been observed between Axid and theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility** — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

**In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.**

**Pregnancy — Teratogenic Effects — Pregnancy Category C** — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers** — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

**Pediatric Use** — Safety and effectiveness in children have not been established.

**Use in Elderly Patients** — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in younger age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic** — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT (AST), SGPT (ALT), or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular** — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**CNS** — Rare cases of reversible mental confusion have been reported.

**Endocrine** — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

**Hematologic** — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumentary** — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity** — As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other** — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

**Signs and Symptoms** — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg, respectively.

**Treatment** — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP

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Additional information available to the profession on request.



# Report Reference Committee



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## IMMEDIATE PAST PRESIDENT

**Jack F. Menendez, M.D.**

**R**efer to the Report of Reference Committee A for the full report of the Immediate Past President.

### Recommendations

1. That the PIP program be continued next year on Wednesdays and Thursdays. We should also continue to recruit physicians who are knowledgeable about the legislative process to direct the PIP volunteers on a day by day basis.

2. That MAG evaluate the plan in place in Kentucky to increase access to health care by our citizens. (Referred to Reference Committee B.)

3. That the Judicial Council develop clear policy guidelines governing Physician-Officer-Staff relations. (Referred to Reference Committee A.)

### HOUSE ACTION

Adopted Recommendation.

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## REPORT OF THE PRESIDENT-ELECT

**Joe L. Nettles, M.D.**

**T**his past year has been packed with one crisis after another. I would like to thank Dr. Joe Bailey for his able leadership and his tireless devotion to duty. I would also like to thank the MAG staff, especially Interim Executive Director Paul Shanor, and General Counsel Richard Greene, for their able efforts in dealing with all problems as they arose.

Although many areas of concern are still with us, I would like to single out 3 areas that need special attention by the House of Delegates.

### 1. Continued Rise in Malpractice Insurance Premiums

This topic was discussed at last year's House of Delegates and should not be allowed to lie fallow this year. We continue to witness an upward spiral that appears to have no end. The MAG tort reform wheel has not been greased by the last 2 legislative sessions, and it is

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**R**eference Committee C gave careful consideration of its referred reports and resolutions. It was comprised of the following physicians: James L. O'Quinn, Chairman, Richmond; Ellis B. Keener, Vice Chairman, Hall; William G. Whitaker, III, DeKalb; William B. Jones, Hall; William L. Dobes, Jr., Medical Association of Atlanta; Ronald P. Roper, Cobb; Joseph V. Morrison, Jr., Georgia Medical; and Catherine S. Andrews, Cobb.

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*Members of the House attend to the report of Reference Committee C.*

time we start squeaking. There is no justification for Georgia premiums to remain number 3 or 4 in the country. We say that there is no way we can pass a cap on non-economic loss; however, we have not really tried, and that is evidently the one thing that affects the premium more than anything else. Please refer to my recommendation on page 3.

### *2. The Spectre of Mandated Assignment*

Three separate attempts at some form of Mandated Assignment were successfully fought off during the recent Georgia legislative session. The most drastic attempt was an amendment to the C.M.E. Bill by Senator Al Scott of Savannah that would tie mandatory acceptance of Medicare and Medicaid to licensure. Thanks to vigilance and skillful work by Dr. Jim Kaufmann and his able lieutenants, Richard Greene, Paul Shanor and Joe Wood, all three measures were avoided. I asked Senator Scott why he proposed such a measure, and he referred me to Vita Ostrander, a former National President of AARP. Ms. Ostrander felt that such mandates were necessary because the Aetna

Medicare Part B SNAFU was becoming so critical that doctors were threatening to discontinue seeing Medicare patients. Some form of Mandated Assignment has been put into law by 4 states, and a majority of the rest of the states are being threatened by such action. President Bush has already advanced a budget that cuts \$5 billion from last year's Medicare funds despite an increasing aging population and widening technology that should call for an increase.

How will we successfully continue to avoid mandates of Medicare and Medicaid assignment? Only by pointing out to the public that we are taking care of our elderly and needy and therefore there is no need for such action. The State of Washington recently used such public relation tactics to overwhelmingly defeat a state referendum that would have put them in the same position as the doctors of Massachusetts. Through such patient advocacy programs as "Doctor-Care," the component medical societies of Washington see to it that no one lacks medical attention.

The Medical Association of Georgia's newly formed Ad Hoc Com-

mittee on Senior Citizen Advocacy is already exploring ways to see to it that the physicians of Georgia take the initiative before the control is taken out of our hands. This Committee and the Public Relations Committee will have suggestions for ways to advance this initiative.

### *3. The Justice Department Threat*

For the past 3 months a Federal Grand Jury has convened in Savannah gathering information and hearing testimony as to whether to criminally indict all 30 practicing obstetricians. (The original papers listed 31, but Dr. Richard Lanier, a former MAG Director, recently died of a coronary.) There are allegations that 5 years ago these obstetricians conspired to fix prices. I am confident that no action taken by those physicians constitutes an intentional F.T.C. or anti-trust violation. To place such high-quality professionals and their families under such stress is unconscionable.

Our President, Dr. Joe Bailey, our Georgia Health Network Director, David Poythress, Richard Greene, Paul Shanor and others have worked hard to come to the relief of our beleaguered fellow physicians, but so far our efforts have not prevailed.



We plan to continue our efforts working through the AMA as this circumstance could have caught any of us at a time when the rules of the game were vague and untested and knowledge of such rules was non-existent. We are hopeful that no criminal indictments will be issued.

By the time the House of Delegates meets, the decision of the Grand Jury possibly will be evident. If a criminal indictment is made, then Georgia physicians should coordinate state and national efforts toward financial and legal relief as the cost — both monetarily and emotionally — has already strained the limits of our colleagues.

Finally, I would like to thank you, the physicians of Georgia, for the privilege of serving with you in this period of crisis. I often hear the trite remark "I wouldn't want my son to be a doctor." Back in college when I first made up my mind to go to medical school, my friends said, "Joe, you shouldn't do that. Socialized medicine is right around the corner." That may be the case, but it's still the greatest profession and the opportunities are enormous. If we work together, we can keep it that way.

## Recommendation

That MAG mount a new all-out effort to gain control on the spiraling costs of medical liability insurance through (1) pushing through the legislature the obstetrical relief package developed this year, and (2) seeking to place a cap on awards for non-economic loss.

## HOUSE ACTION

Adopted with commendation.

## MAG COUNCIL ON LEGISLATION

**James A. Kaufmann, M.D.**

### Patients . . . and Their Physicians Win on Major Issues!

The 1989 Session of the Georgia General Assembly began on January 9 and came to a long awaited end on Wednesday, March 15 at 6:33 p.m. as Lt. Governor Zell Miller and Speaker Tom Murphy simultaneously gavelled the session to close. This session saw the introduction of 1,136 House Bills, 559 House Resolutions, 406 Senate Bills, and 275 Senate Resolutions making a total of 2,376 pieces of legislation. As is usual, MAG had to follow the largest number of bills of any organization or lobbying group.

Even though the new sales tax dominated the media, health-related legislation commanded a major portion of the legislature's time and energy. Your MAG Legislative team followed health-related legislation ranging from access to health care all the way to a statute dealing with embalming a body prior to an autopsy.

Some of the major pieces of legislation are as follows:

**H.B. 209 — Nurse Protocol.** The original version of this bill would have greatly expanded the powers of nurses and physician assistants to treat patients without directly consulting with a physician. As passed, H.B. 209 is a reasonable solution to the problem of permitting nurses and P.A.s to practice under "protocols." The Georgia Nurses Association stated prior to the Session that they intended to introduce a brand new, expanded scope of nursing legislation comprehensively re-writing the Nurse Practice Act. The passage of H.B. 209 became so difficult and burdensome that they abandoned for 1989 this new Nurse Practice Act. Expect to see it, however, in 1990.

**H.B. 702 — Continuing Medical Education.** Of the three mandatory CME bills introduced in 1989, the only one that remains active for consideration in 1990 is H.B. 702, the one that is most favorable to our position. However, this was one of two bills amended (and a third independent bill that was introduced) unfavorably which would make it mandatory for physicians to accept both Medicare and Medicaid patients as a condition for licensure or scholarship. Rep. George Green, M.D., Georgia's only M.D. State Legislator was able to stop this onerous amendment and H.B. 702 from passing in 1989.

**H.B. 1020 — Mandatory Acceptance of Medicare and Medicaid Patients.** This bill would require that an applicant for a medical license must accept and treat Medicare and Medicaid patients. This issue will be one of the major fights in the 1990 Session. There appears to be considerable support for the concept. It will take a dedicated effort on your part to educate your legislators now about the problems with this type of licensure requirement.

**S.B. 289 — Collateral Source.** We are pleased to report that S.B. 289, the major attack on the collateral source disclosures is still stalled in the Senate Rules Committee. Thank you for all of your efforts and help. We hope you will thank our friends on the Senate Rules Committee, especially its Chairman, Senator Nathan Dean of Rockmart and thank Lt. Governor Zell Miller for his strong help in stopping S.B. 289.

**H.B. 379 — Physical Therapists.** Another attempt by physical therapists to expand their scope of practice was stopped again this year in the House Health & Ecology Committee. It was an attempt for them to be able to practice independently without even having to consult with a physician before commencing treatments on patients.

**H.B. 1011 — OB Tort Reform.** MAG took the initiative to introduce a



major tort reform bill in 1989. It will be a major part of MAG 1990 legislative effort. H.B. 1011 is an attempt to establish a mandatory, binding, fault-based arbitration system for cases involving the delivery of an infant.

**Teamwork Pays! Thanks to the Many Physicians and Auxilians Who Worked Hard to Ensure a Successful Session.**

A cooperative effort by physicians and auxilians led the way to a very successful 1989 Session. MAG is grateful for the many personal and written contacts made by physicians and auxilians on behalf of our legislative goals. The Physician Involvement Program (PIP) was once again instrumental in influencing the outcome of legislation. Although PIP participation was down this year, we hope the new format of having an experienced physician group leader each day helped make the experience more meaningful and more productive than in past years. It is critical that PIP be revitalized and become even more effective.

Enough great things cannot be bestowed upon the Auxiliary and its Phone Bank. Our legislative staff has commented that they could really "feel" the positive impact and effectiveness of the phone bank when talking to legislators. The prior planning of those in charge of the Phone Bank really paid dividends. Special thanks to Mrs. Jan Collins, Mrs. Cherie Dennis, Mrs. Mary Agraz, Mrs. Maureen Vandiver, Mrs. Barbara Tippins, Mrs. Grace Walden, Mrs. Anne Galloway, Mrs. Sandra Burk, Mrs. Ann Purcell, Mrs. Margaret Watson, and Mrs. Anne Staley for planning such an impressive and proficient Phone Bank.

The patients and physicians also owe special thanks to Georgia's only physician legislator, Representative George Green, M.D. of White Plains, Georgia. Rep. Green clearly emerged this Session as a leading spokesman on health care issues.

On behalf of the citizens of Georgia, MAG extends its congratulations and thanks to Rep. George Green, M.D., for his untiring efforts to improve the quality of health care in Georgia.

1989 saw another successful Doctor-of-the-Day Program. MAG members provided needed medical care to all persons at the Capitol through this very popular program. 1989 also saw Mrs. Alice Kaufmann as the new Medical Aid Station Nurse. She served full-time during the session and received well-deserved praises from legislators, Capitol staff and from the public at large. On several days Nurse Kaufmann and the Doctor of the Day treated in excess of 50 patients. They ably treated everything imaginable from headaches, to broken bones, to heart disease. They even detected a patient who had cancer.

We would be remiss if we didn't thank another important group. A grateful THANK YOU is extended to the MAG Mutual Insurance Company for their tireless support and assistance again this year. Special thanks to Dr. Charles Hollis, Chief Executive Officer; Mr. Tom Gose, President; Marilyn Allen, Staff Attorney; and Mr. Robert Constantine, Corporate Attorney for their unselfish and dedicated service.

**Groups Working Together**

Some specialty groups have considered, or even had introduced, legislation to meet certain needs or goals of that particular group. Even some individual physicians acting virtually alone have had bills introduced. While continuing to recognize the rights of any group or individual to act independently, it is generally recognized that a unified and united medical lobby will become more effective than if divided; therefore, persons or groups considering the introduction of legislation are strongly urged and encouraged to submit such proposals to the Legislative Council for consideration, comparison to MAG policy, and discussion prior to its being

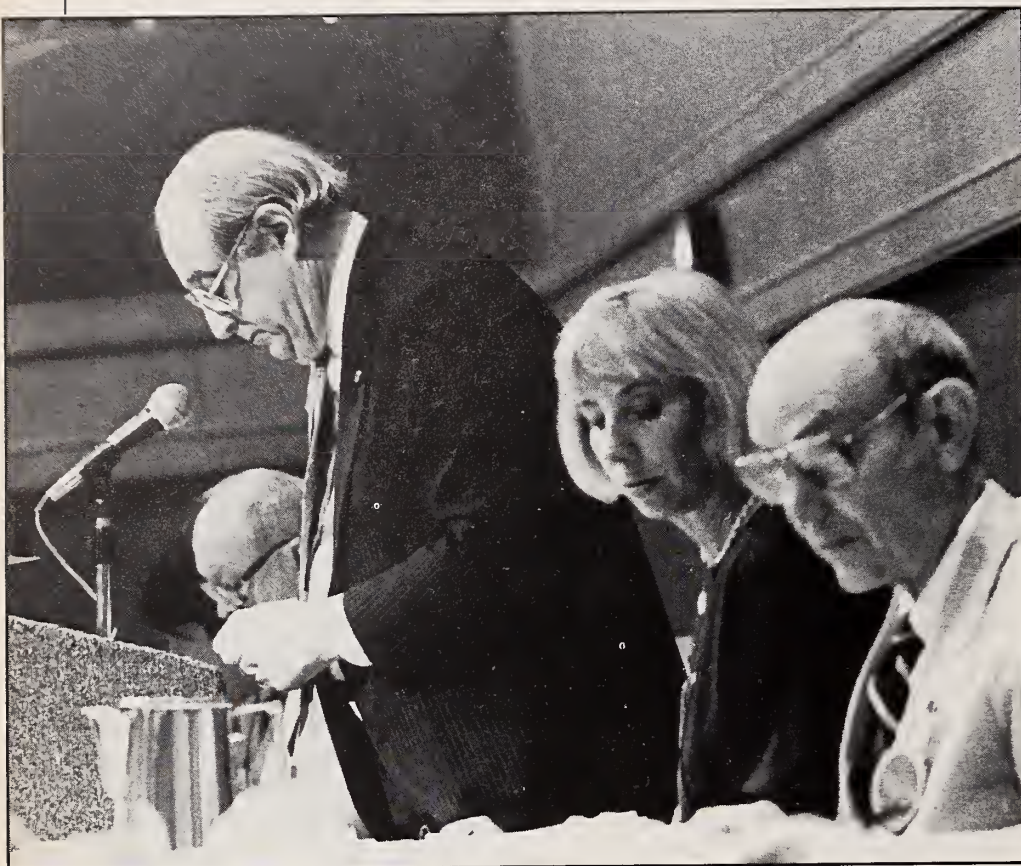
introduced. Likewise, whenever such persons or groups are contemplating or have already hired independent lobbyists or "consultants" they are also strongly urged and encouraged to discuss such with the Legislative Council prior to making such a decision. It needs to be clearly understood that neither request for "consultation" is designed to prevent any group or person from taking whatever action they feel is appropriate. The Georgia Society of Anesthesiologists, Inc. is especially to be commended for instructing its independent lobbyist to work closely and directly with and under the guidance of MAG's lobbying effort. Remember, "united we stand, divided we fall!"

The newly restructured Legislative Council performed beyond expectation. 1988 House recommended a re-structuring of the Legislative Council in an attempt to revitalize and increase its impact. The re-structuring was successful. The new, expanded Legislative Council met several times prior to the Session as we prepared and formulated our policies and positions. Individual participation was excellent and those members who attended the meetings are to be commended for their efforts. Several new pieces of legislation were introduced as a direct result of Legislative Council suggestions. This effort to raise participation will continue into next year. It is imperative if we are to maintain our strong voice at the Capitol.

It took a cooperative effort by physicians and auxilians who participated in the political process to bring about the many successes MAG enjoyed this past year. 1989 is perhaps one of the most successful Sessions ever for MAG. It was the *Personal Physician Involvement* that is now, and always will be the *Key to MAG's Success* at the Capitol.

Thanks is also extended to our staff for their tireless, seven days-a-week effort. Thanks to your help and their help, MAG did not lose a single major issue last year. The op-





(L to R) Paul Shanor, MAG Executive Director; Ralph Tillman, M.D., MAG Secretary; James Kaufmann, M.D., Speaker of the House; Mary Lou Stephens, Parliamentarian; and Joseph Bailey, Jr., M.D., MAG President, listen to the report of Reference Committee C.

posite is reality as MAG successfully stopped issues such as an attack on the Collateral Source rule by plaintiff's attorney's, nurse's mandatory third party reimbursement, expanded scope of practice for physical therapists. I wish to express special thanks to Mrs. Donna Glass, secretary to our Legislative Team. She worked long hours and weekends manning the office at MAG headquarters while the legislative staff was more than busy at the Capitol.

It must be emphasized that the many successes of this past session are the direct result of the individual participation in the political process by YOU, other physicians and auxiliaries. Each of you who contributed to GaMPAC, wrote or called a legislator, met personally with your Senator or Representa-

tive, participated in the Physician Involvement Program, or worked at the phone bank are to be commended and congratulated for a "job well done!"

## Recommendations

1. That the re-vitalized activities of the Legislative Council be continued and that strong efforts be made to ensure that every specialty society is actually represented at each and every meeting.

2. That the Legislative Council be composed of members who will commit to serve MAG and the Council by attending Council meetings and by committing to dedicate at least three full days at the Capitol during the 1990 Session.

3. That specialty groups and individual physicians be encouraged

to submit any proposed legislation to the Legislative Council prior to its introduction.

4. That specialty groups be encouraged to consult with the Legislative Council prior to hiring independent lobbyists or consultants.

5. That individual MAG members and their spouses be encouraged to not only contribute to GaMPAC, but more importantly to personally participate in legislative activities and campaigns.

6. That MAG members make themselves, their staff and their offices and equipment (i.e., telephone, copiers, printers, and computers, etc.) available to help the candidates of their choice.

7. That Mrs. Jan Collins, Mrs. Cheri Dennis, Mrs. Grace Walden, Mrs. Anne Staley and the many Auxiliary volunteers be commended for the successful 1989 Telephone Bank.

8. The MAG staff, the Legislative Council, and the Auxiliary work together prior to the 1990 Session to improve and enhance the effectiveness of the phone bank.

9. That all members of the Auxiliary who participated as a telephone bank volunteer be written a thank you letter by the Legislative Council Chairman.

10. That Dr. Charles Hollis and MAG Mutual Insurance Company be commended for going above and beyond the call of duty by its effective assistance during the General Assembly.

11. That the 1989 Legislative Seminar, which is being held on August 4 through August 6, 1989 at the King & Prince Hotel have its theme dedicated to educating physicians on how to combat the attempts to legislate mandatory Medicare/Medicaid assignment.

## HOUSE ACTION

Adopted with commendation.



## MAG MUTUAL SUPPLEMENTAL REPORT

**Charles D. Hollis, Jr., M.D.**

**G**ood news is here. Loss data submitted to the Georgia Insurance Commissioner justifies a reduction in professional liability premium rates. That is very good news for physicians and for the people of Georgia.

More than anything else, it means that tort reform works. The reforms which physicians, MAG and MAG Mutual Insurance Company fought for and passed in the 1987 Legislature are taking effect — actually sooner than we thought. For example, tort reform included a requirement that a medical expert witness had to attest that negligence had occurred before a suit could be filed. Since that time there has been a big decrease in the number of suits. At MAG Mutual, we are seeing almost a 50% decrease in the number of claims compared to pre-tort reform days.

Actuaries, those professionals who advise insurance companies and the Insurance Commissioner about premium rates, look at the trend of losses and determine the amount of premiums that will be necessary to pay those losses. In medical liability insurance, there is a long lag period between the time a premium is paid and the time all costs are settled which are attributed to the premium in a certain year. For instance, it will be 1999 before all the money is paid out for claims arising out of patient treatments occurring in 1989.

For that reason, actuaries and the Insurance Commissioner have not allowed MAG Mutual to set premiums on the basis of its data alone. At seven (7) years of age, we are too young for all of our losses to be known. Rates have been based on loss data from all sources in Georgia over a longer period of time.

For the commercial insurer which has been in operation in Georgia for more than twenty (20) years also to report lower losses and justify a rate reduction is very encouraging for MAG Mutual. It means that MAG Mutual will also be able to reduce its rates. It has not been determined how much of a reduction is to be made yet, because there has not been time to analyze all of the loss data submitted to the Insurance Commissioner's Office justifying the rate reduction. In addition our reinsurers at Lloyd's of London are recognizing improved loss data and have lowered the rates for excess limits effective July 1. Of course these now lower rates will be announced soon too.

As a domestic mutual company, the expenses at MAG Mutual have been about 10% less than the primary commercial competitor, so the Insurance Commissioner allows us to charge about 10% less on average through our various discount programs. The commercial company does not offer these discount programs. This makes MAG Mutual different, among other things. With the change in rates it will be possible to offer and expand various discount programs, especially the LEAD Program which has been widely accepted. There should be enough money also to make a substantial reduction in the direct premium charges.

The hard work by Georgia physicians to effectuate tort reform and in supporting the development of a physician-owned insurance company is paying off. The commercial companies did not participate in the effort to accomplish the significant reforms which are now improving the legal climate in Georgia. As soon as the data can be analyzed, MAG Mutual will make a report to its insurers and to the Medical Association of Georgia as to the benefits that can be offered.

### **MAG Mutual Insurance Agency, Ltd.**

The MAG Mutual Insurance Agency, Ltd. has expanded its product lines and during the next year will be able to offer complete insurance coverage in many areas including life, accident and health and disability. It is seeking the support and endorsement of MAG in marketing its products. This will be another service the MAG Mutual can offer Georgia physicians. These will be good insurance products offered at competitive prices. It will be possible for the physician to handle all insurance needs in one agency. The insurance products are also available to the physician's office staff. The Agency was first developed as a convenience to MAG Mutual insurers, but during the past year it began to be profitable also. Any profits realized from commissions on insurance sold through the Agency, accrues to the parent company, MAG Mutual, and serves to offset some of the burden of the liability premiums.

MAG Mutual has recruited a very professional staff for its Agency and will be publicizing the benefits of its insurance programs to physicians more aggressively during the coming year.

### **Federal Income Tax**

The only bad news to be brought to physicians this year is that under the Federal Tax Reform Act of 1986, damaging income tax regulations were promulgated which adds 7.5% to every liability premium. These regulations probably were not intended to so harshly hit mutual physician-owned insurance companies which exist solely to provide the insurance necessary for a doctor to practice medicine. However, the unfair and burdensome aspects of the regulations under this law were not recognized by our congressmen.





*James L. O'Quinn, Chairman of Reference Committee C, at the podium, answers a question regarding his committee's report to the House.*

Certain aspects of the law are difficult to believe. For instance, 15% of the income from "tax-free" municipal bonds are taxed. A substantial portion of unearned premium, premium which can be earned totally over the twelve month term of the policy, are taxed. This is tax-

ation on money which has not been earned. Finally, a portion of the loss on reserves, those bills payable on claims which are already in house, is also taxed. These elements of the tax law hit physician-owned companies unfairly and should be changed. When the 7.5% federal tax

is added to the 3% state tax on premiums, 10.5% of the premium dollar goes to direct taxes before any other expenses are incurred.

Key members of the U.S. Congress have professed an interest in instituting some way to relieve the burdensome premiums which physicians have to pay for professional liability insurance. So far, nothing has been done. It would be very easy and relatively non-controversial to exclude mutual physician-owned companies from the unfair tax. We will be seeking the help of MAG in informing our congressional delegation about this problem and asking for their help in obtaining relief.

### Recommendation

MAG Mutual requests that MAG inform its senators and congressmen about the facts of this erroneous tax and work through its staff and legislative committee to obtain relief. MAG Mutual would like to have the Supplemental Report referred for the purpose of obtaining official support of this recommendation.

### HOUSE ACTION

Referred to the MAG Board of Directors.

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## MEDICAL PRACTICE COMMITTEE

**Rodney L. Smith, M.D.,  
Chairman**

**R**efer to the Report of Reference Committee B for the full report of the Medical Practice Committee.

### Recommendations

1. That the Medical Association of Georgia give cautious support only to the "National Study of Resource-Based Relative Value Scales for Physician Services" and that the Association conduct, through this



Committee or any other appropriate Committee they may determine, a full evaluation of the study by all affected parties. Further, the Committee recommends that the Association not give full support to the AMA/Harvard relative value study until the concerns of all physicians are appropriately addressed.

(*Referred to Reference Committee B.*)

2. That the Medical Association of Georgia consider developing a series of medico-legislative "town meetings," open to MAG members, structured to provide physicians and invited legislators with loosely structured forums to discuss common approaches to meeting the health care needs of our fellow Georgians.

## HOUSE ACTION

Adopted Recommendation 2 as amended: "That the Medical Association of Georgia encourage component medical societies to have at least one meeting with their local legislative delegation prior to the convening of the next legislative session to discuss common approaches to meeting the health care needs of our fellow Georgians."

## THIRD PARTY PAYORS COMMITTEE

**C. Peter Lampros, M.D.**  
Chairman

**R**efer to the Report of Reference Committee B for the full report of the Third Party Payors Committee.

Subsequently, meetings were held with Commissioner Evans who has agreed to convene with MAG a committee of industry representatives to iron out many of the UR problems.

## Recommendations

1. That the Association continue to rigorously oppose Medicare laws and regulations which work to the detriment of good patient-physician relations and services. (*Referred to Reference Committee B.*)

2. That the MAG work aggressively with the Georgia insurance commissioner, the insurance industry and other payors to improve the administration of prior authorization and other utilization review programs.

## HOUSE ACTION

Adopted Recommendation 1 with commendation.

## RESOLUTION 1 Banning of Tobacco Product Advertisement Cobb County Medical Society

*Whereas*, the smoking of tobacco products has been conclusively and scientifically proven to represent a major etiological agent in development of malignant disease of the upper and lower respiratory passages; and

*Whereas*, the Canadian government has now banned all advertising of tobacco products in the print and television media with the exception of those publications being distributed in the United States of America; and

*Whereas*, The Canadian government has requested that all American publications entering their country adhere to this ban on the carrying of tobacco advertisements; and

*Whereas*, the State of California has recently passed a law known as Proposition No. 99 increasing the tobacco tax on each package of cigarettes from fifteen to thirty-five cents per package; and

*Whereas*, organized medicine is expected to and must stand as a beacon safely guarding the American public away from those known hazards to their health; now, therefore, be it

RESOLVED, that the Medical Association of Georgia go on record as opposing the placement of tobacco product advertising in the print media in the United States as well as on radio and television channels; and be it further (*Referred to Reference Committee D.*)

RESOLVED, that the representatives of the MAG to the AMA House of Delegates propose that legislative efforts directed toward the banning of tobacco product advertising be instituted in the Senate and House of Representatives of the United States.

## HOUSE ACTION

Adopted second RESOLVE as amended: "That the MAG delegation to the AMA House of Delegates support efforts directed toward banning the advertising of tobacco products in the United States."

## RESOLUTION 4 Medical Examiners System Muscogee County Medical Society

*Whereas*, the Legislature of the State of Georgia passed the Georgia Post Mortem Act in 1953 which defines the duties of Coroners, the Director of the State Crime Laboratory and various other legal and police authorities in regard to certain post mortem examinations; and

*Whereas*, this current system is antiquated, outdated and not responsive to the prompt needs of the people of Georgia by utilizing appropriate scientific methods and

trained and qualified physicians (forensic pathologists) to provide an adequate service for the protection of the citizens of Georgia, not only on the State level but also within each county and municipality; now, therefore, be it

RESOLVED, that the Medical Association of Georgia petition the Legislature and the Governor of the State of Georgia to replace the existing Coroner system with a state-wide Medical Examiner system, and be it further

RESOLVED, that the Governor of the State of Georgia establish an independent and permanent Board to direct and oversee the development and operation of such Medical Examiner System and that such Board be composed of members of the legal and medical professions, of law enforcement representatives and of citizens-at-large all of whom, because of their special knowledge or interest, can provide meaningful contributions to such Board, and be it further

RESOLVED, that the responsibilities for the operation of the currently existing State Crime laboratory be transferred to such Board as mentioned above.

### HOUSE ACTION

Adopted with commendation.

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### RESOLUTION 5 Stratified Licensure Medical Student Section

*Whereas*, the history of medicine is a history of broad based holistic healing dedicated to the well-being of the whole patient; and

*Whereas*, history, ethics, and a sense of right demand that present and future physicians uphold this tradition; and

*Whereas*, there is a clear and evident practice, desire, and willing-

ness of physicians to utilize, consult with, and refer to colleagues with more specialization and expertise in a given area as the patients' condition dictates; and

*Whereas*, there are currently sufficient safeguards in place, including hospital privilege guidelines, and a physician's awareness of his or her own limitations and abilities, that prevent abuses of the physicians' privileges to treat; and

*Whereas*, further government sponsored intervention in the practice of medicine is both inadvisable, counterproductive, and not in the best interests of our patients; therefore, be it

RESOLVED, that the Medical Student Section of the Medical Association of Georgia request the MAG House of Delegates to adopt an official position opposing any effort on the part of government to implement or impose any stratified, tiered, or restrictive licensure structure which limits the practice of a duly licensed physician.

### HOUSE ACTION

Adopted with commendation.

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### RESOLUTION 13 Identification of Tobacco as a Cause of Death

**Charles A. Lanford, M.D.**

*Whereas*, Oregon and Utah have become the first states to change their death certificates to allow tobacco use to be identified as a contributing factor to the cause of death; and

*Whereas*, the American Medical Association House of Delegates has called on the AMA to draft model

legislation which will allow tobacco to be identified on death certificates as a contributing factor to the cause of death; and

*Whereas*, the AMA has also urged state medical associations to develop mechanisms allowing such identification of tobacco on death certificates, therefore be it

RESOLVED, that the Medical Association of Georgia introduce legislation to allow tobacco to be identified on Georgia death certificates as a contributing factor to the cause of death.

### HOUSE ACTION

Adopted as amended: "That the Medical Association of Georgia encourage physicians to list tobacco on Georgia death certificates as a contributing factor to the cause of death when appropriate."

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### RESOLUTION 14

#### Prompt Payments in Insurance Claims

**Hall County Medical Society**

*Whereas*, physician's payment for valid procedures are often being unnecessarily withheld or delayed throughout the insurance industry; and

*Whereas*, laws are on the books requiring prompt payment for valid procedures, i.e., Georgia Insurance Code Section 33-29-3 allowing 15 working days to process and pay claims; therefore, be it

RESOLVED, the MAG work with the Georgia Insurance Commission and/or the Legislature to enforce Georgia Insurance Code Section 33-29-3 or pass new laws to aid/enforce prompt payment.



**HOUSE ACTION**

Adopted as amended: "RESOLVED, that MAG work with the Georgia Commissioner of Insurance and/or the Legislature to enforce Georgia Insurance Code Section 33-29-3 or pass new laws to aid/enforce prompt payment."

**ATTACHMENT****§33-29-3 Georgia Insurance Code****(8) TIME OF PAYMENT OF CLAIMS.**

(A) All benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss. Should the insurer fail to pay the benefits payable under its policy, other than benefits payable for loss of time, upon receipt of due written proof of loss, the insurer shall have 15 working days thereafter within which to mail the insured or subscriber a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the insured or subscriber a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the insured the reasons the insurer may have for denying such claim or any portion thereof.

(B) Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the ter-

mination of such period will be paid immediately upon receipt of such proof.

(C) Each insurer admitted to transact accident and sickness insurance in this state shall pay interest to the insured equal to 18 percent per annum on the proceeds or benefits due under the terms of the policy for failure to comply with the requirements of subparagraph (A) or (B) of this paragraph.

**(9) PAYMENT OF CLAIMS.**

(A) Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other

Revised, 1984

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**RESOLUTION 16****Proposal to Amend the Acquired Immune Deficiency Syndrome Legislature Act****Georgia Medical Society**

*Whereas*, AIDS is a potentially fatal disease caused by the HIV virus and communicable through contact with bodily fluids of infected persons, including those who are asymptomatic; and

*Whereas*, health care providers are at significant risk of coming in contact with bodily secretions of patients who secrete the HIV virus; and

*Whereas*, testing for this virus is often a part of the evaluation of pa-

tients who are considered at high risk or even possible risk for having the virus; and

*Whereas*, patients may decide to not allow the test to be done; and

*Whereas*, this may place health care workers at higher risk; and

*Whereas*, many portions of the explanation regarding this disease process need not or may not be discussed with certain patients, therefore be it

RESOLVED, that the O.C.G.A. 31-22-9.2 be amended to provide that:

1. physicians be permitted to test individuals considered to be at high risk and individuals for whom the risk factor is unknown for the HIV virus as a means of evaluating their patients in an appropriate fashion as well as providing protection to health care providers;

2. that physicians be permitted to test for the virus in an appropriate fashion utilizing their professional judgment without the necessity of obtaining informed consent of the patient prior to testing;

3. that physicians and other health care professionals utilize reasonable historical medical standards to counsel patients regarding the implications of HIV testing prior to the test;

4. physicians and health care providers utilize strictest criteria to maintain patient confidentiality regarding HIV testing.

**HOUSE ACTION**

Adopted as amended: "RESOLVED, that the O.C.G.A. be amended to provide that physicians be permitted to test for the HIV virus in an appropriate fashion utilizing reasonable historical medical standards and their professional judgment."

## **RESOLUTION 21**

### **State Funding of Grady Memorial Hospital**

#### **Medical Association of Atlanta**

*Whereas*, the people of Fulton and DeKalb Counties pay a multiple (6-7 times) of the amount, through taxation on property, paid by the people of Richmond County for the health care of indigent patients; and

*Whereas*, indigent patients from the northwest portion of the State of Georgia with elective disease must travel 200 miles, more or less, for care at the University Hospital of the Medical College of Georgia, and

*Whereas*, Grady Memorial Hospital has the capability to provide high quality care for patients with elective disease, as well as injuries; and

*Whereas*, traumatized indigent patients from northwestern Georgia have to travel a long distance, consuming valuable time resulting in delay in health care; and

*Whereas*, Grady Memorial Hospital is an excellent trauma center of Level I quality; and

*Whereas*, relatives and friends from the northwestern section of Georgia visiting patients in the state Hospital in Augusta must travel 200 miles, more or less; therefore, be it

RESOLVED, that the State of Georgia fund 33 percent of the Grady Memorial Hospital annual budget in order that indigent patients in northwest Georgia, outside of Fulton and DeKalb Counties, should receive health care at Grady Hospital; and be further

RESOLVED, that any other city-county hospital whose situation is very similar to that of the above described, and which hospital exists for the purpose of the care of indigent patients, may also receive similar financial support from the State of Georgia.

## **HOUSE ACTION**

Amended by substitution: "RESOLVED, that MAG go on record in support that the State of Georgia provide financial support to all non-federal hospitals for the purpose of the care of indigent patients."

## **RESOLUTION 22**

### **Labeling to Better Identify Prescribed Medications**

**John T. Yauger, M.D.**

*Whereas*, generic substitution for prescribed medication is becoming more commonplace; and

*Whereas*, the nomenclature used to identify generic drugs is often confusing to patients and/or their physicians; and

*Whereas*, such confusion may be adverse to the best interests of our patients; now, therefore be it

RESOLVED, that the Legislative Council of the Medical Association of Georgia be directed to work to secure passage (during the 1990 Georgia General Assembly) of legislation that would require labeling on all prescriptions dispensed to non-hospitalized patients that would show both the generic name of the medication dispensed and the brand name of the medication prescribed (for which the generic drug is substituted).

## **HOUSE ACTION**

Adopted as amended: "RESOLVED, that the Legislative Council of the Medical Association of Georgia be directed to work to secure passage (during the 1990 Georgia General Assembly) of legislation that would require labeling

on all prescriptions dispensed to non-hospitalized patients that would show the generic name and the brand name when a brand name drug is substituted with a generic drug as follows: *Generic Name* substituted for *Trade Name* as in 'Furosumide substituted for Lasix'."

## **RESOLUTION 25**

### **Informed Consent**

#### **Cash Stanley, M.D.**

*Whereas*, the intent of Georgia's new Informed Consent statute, effective last January 1, is beneficial insofar as it seeks to assure patients' awareness of possible complications to surgery; but

*Whereas*, in practical implementation this law has directly led to numerous adverse results in patient care after some patients, apprised of the remote possibility of accidental "loss of limb, paralysis, brain damage, cardiac arrest, or death" from a minor or routine surgical procedure, have decided against such procedures, despite the medical necessity for them; and

*Whereas*, in practical implementation the relating of remote risks has an especially dramatic effect upon less educated patients, who may become confused or frightened by the presumably routine warnings prescribed by law; as a result, informed consent, rather than educating patients on a surgical procedure, has the distinct possibility of *miseducating* them as to the probable consequences of surgery; therefore be it

RESOLVED, that the MAG, if deemed necessary for good patient care in our state, propose amendments to the current informed current law, so that the physician's informing statement, as required by



law, be more representative of actual surgical probabilities of outcome.

#### HOUSE ACTION

Referred to the MAG Council on Legislation for its consideration and appropriate legislative action.

### RESOLUTION 32

#### Freedom of Choice in Health Insurance

**Ralph A. Tillman, M.D.,  
Secretary**

*Whereas*, in recent years the cost of health care insurance has escalated at an alarming rate; and

*Whereas*, today there are approximately 37 million Americans without health insurance; and

*Whereas*, both the cost of health care insurance and number of uninsured are directly related to the explosion of mandated health insurance benefit laws; now, therefore be it

RESOLVED, that the Medical Association of Georgia support legislation to return the rights of individuals to a freedom of choice in health insurance in order that each individual might purchase "no frills" health insurance tailored to his or her personal needs, desires, and financial capabilities.

#### HOUSE ACTION

Referred to the MAG Third Party Payors Committee for study and report to the MAG Board of Directors.

### RESOLUTION 34

#### Legalization of Drugs

**James Q. Whitaker, M.D.**

*Whereas*, violence is a common occurrence as a result of the illicit profit motive from illegal drug trading; and

*Whereas*, laws prohibiting recreational usage of drugs are seemingly unenforceable; therefore, be it

RESOLVED, the Medical Association of Georgia support the legalization of drugs under controls such as those for alcohol usage, and suggest the revenues realized from such controlled sales be used to directly reduce the national debt, and be it further

RESOLVED, our AMA delegation support the legalization of drug sales controlled by government.

#### HOUSE ACTION

Filed.

### RESOLUTION 42

#### Nursing Homes and Personal Care Homes

**Medical Association  
of Atlanta**

*Whereas*, recognizing the current problems with nursing homes and personal care homes, the Committee on Aging of the Medical Association of Atlanta proposes the following resolution:

RESOLVED, that the MAG Senior Citizens Advocacy Committee study the current status of nursing homes and personal care homes in Georgia; and be it further

RESOLVED, that the MAG Senior Citizens Advocacy Committee advocate for universal optimal care in

nursing homes and personal care homes for their residents; and be it further

RESOLVED, that the MAG Senior Citizens Advocacy Committee advocate for appropriate legislation to ensure the implementation of these recommendations.

#### HOUSE ACTION

Adopted with commendation.

### RESOLUTION 43

#### Battered Women

**Teresa E. Clark, M.D.  
Luella Klein, M.D.**

*Whereas*, domestic violence in the United States today is a frequently common occurrence; and

*Whereas*, women are overwhelmingly the victims of this violence; and

*Whereas*, recognition of this violence directed toward women may be underreported and underrecognized because of both the woman's own reluctance and fear, as well as failure, of her health care provider to recognize this cause of her injury; and

*Whereas*, the American College of Obstetricians and Gynecologists (ACOG) led a national effort to educate its members regarding the recognition of the battered woman, her treatment, and referral to appropriate support systems; now, therefore be it

RESOLVED, that the Medical Association of Georgia (MAG) commend ACOG for its leadership in educating physicians regarding recognition and care of battered women; and be it further

RESOLVED, that the MAG further these efforts by disseminating to its members information on recognition and treatment of battered women including statewide referral

support systems at a cost of \$4600 for 6500 bulletins; and be it further (Referred to Reference Committee F.)

RESOLVED, that the MAG support in concept legislative efforts to address this problem.

### HOUSE ACTION

Adopted first and third RESOLVES with commendation.

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## RESOLUTION 47

**Inflammatory  
Language Contained in  
Medicare Regulations**  
DeKalb Medical Society

*Whereas*, the regulations as promulgated by the Health Care Financing Administration for the Medicaid programs contain inflammatory language when discussing reasons for denial of payment, and which can be used by the PRO of Georgia (Georgia Medical Care Foundation) when denying payment for "sub-standard quality care"; and

*Whereas*, the regulations allow the PRO to use the phrase "sub-standard quality care" when communicating with patients regarding the reason for denial of payment; and

*Whereas*, the use of "standards" to measure quality care is a poor concept in that it may lead to rationing of care and unnecessary liability exposure for physicians; therefore be it

RESOLVED, that MAG work with the AMA and the Georgia Congressional delegation to rescind the inflammatory language in the rules and to eliminate the use of "standards" as a measure of quality care and a basis for denial of payment.

### HOUSE ACTION

Adopted as amended: "RESOLVED, that MAG work with the AMA and the Georgia Congressional delegation to rescind the inflammatory language in the HCFA rules and regulations and to eliminate the use of 'standards' as a measure of quality care and a basis for denial of payment."



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# Report Reference Committee

# D

## SENIOR CITIZENS ADVOCACY COMMITTEE

**Joe L. Nettles, M.D.,  
Chairman**

**D**uring its meeting of May 5, Reference Committee D gave careful consideration to its referred reports and resolutions. The following physicians were members of that Committee: J. Robert Logan, Chairman, Georgia Medical Society; Spencer S. Brewer, Jr., Vice Chairman, Medical Association of Atlanta; Robert A. Burns, Whitfield-Murray; Rodrigo Cabezas, Medical Association of Atlanta; Kenneth L. Goldman, Muscogee; Thomas L. Haltom, Cobb; John A. Hudson, Bibb; and Jim Lee Rogers, Floyd-Polk-Chattooga.

**R**efer to Report of Reference Committee B for the complete report of the Senior Citizens Advocacy Committee.

### Recommendations

After further discussion, the Committee agreed to recommend that:

1. MAG urge physicians to continue to see Medicare patients and help them deal with current or ongoing problems with Medicare. (Referred to Reference Committee B.)

2. MAG educate physicians and senior citizens about changes in the Medicare program and the potential impact of these changes on the physician and the beneficiary.

\* 3. A patient information brochure developed by the Indiana Medical Association, entitled "Medicare: What you should know,"

be revised for distribution in Georgia. (Referred to Reference Committee F.)

\* 4. An easily revised fact sheet regarding Medicare be prepared. (Referred to Reference Committee F.)

\* 5. A hotline for Medicare patients be established in MAG headquarters on a one-year trial basis. (Referred to Reference Committee F.)

6. MAG pursue the feasibility of developing voluntary medical care and/or Medicare participation programs for those senior citizens living at or below 150% of the Georgia poverty level. (Referred to Reference Committee F.)

7. Representative of the AARP and other appropriate agencies be invited to participate in the development of the education process.

\*Fiscal Note: Funds included in Public Relations Committee Budget.

### HOUSE ACTION

Adopted Recommendations 2 and 7.





Members of Reference Committee D included (L to R): John A. Hudson, Rodrigo Cabezas, and Kenneth L. Goldman.

## RESOLUTION 1

### Banning of Tobacco Product Advertisement

#### Cobb County Medical Society

**R**efer to the Report of Reference Committee C for the complete text of Resolution 1.

RESOLVED, that the Medical Association of Georgia go on record as opposing the placement of tobacco product advertising in the print media in the United States as well as on radio and television channels; and be it further

RESOLVED, that the representatives of the MAG to the AMA House of Delegates propose that legislative efforts directed toward the banning of tobacco product advertising be instituted in the Senate and House of Representatives of the United States. (Referred to Reference Committee C.)

#### HOUSE ACTION

Adopted first RESOLVE.

## RESOLUTION 8

### Section Recognition of Service

#### Medical Student Section

*Whereas*, it is appropriate for an organization to show its appreciation for and recognize the accomplishments of persons who have advanced the goals of that organization or who have rendered exceptional service to that organization; and

*Whereas*, the Medical Association of Georgia Medical Student Section has no mechanism to recognize outstanding service to the Section, to medical education, and/or humanity; and

*Whereas*, during his career, Charles Richard Drew, M.D. made advances which forever changed and made better the quality of medical care for all people;<sup>1</sup> and

*Whereas*, Dr. Drew was consistently a proponent of excellence in medical education and in medical practice; therefore be it

RESOLVED, that the Medical Student Section ask the Medical As-

sociation of Georgia to establish the Charles Richard Drew Award; and be it further

RESOLVED, that that Medical Student Section be allowed to present, on an annual basis, this award to persons, who are not members of the Medical Student Section, whose services to the Medical Association of Georgia Medical Student Section, medical education, the medical profession, and/or humanity are exemplary.

<sup>1</sup>Wynes, C.E. *Charles Richard Drew: The Man and the Myth*. Champaign, University of Illinois Press (1988).

Fiscal Note: \$50.00 per annum.

#### HOUSE ACTION

Adopted as amended: "That the Medical Student Section be allowed to present an annual MAG award to individuals for their service to the Student Section or to the medical profession as a whole. Details of funding and presentation of such an award should be submitted by our Student Section to the MAG Board of Directors for its approval."



### RESOLUTION 23

#### Commendation of Louis W. Sullivan, M.D.

#### Medical Association of Atlanta

*Whereas*, Louis W. Sullivan, M.D., has made vast contributions to medical education and the practice

of medicine both as a physician and as President of the Morehouse School of Medicine; and

*Whereas*, he has served organized medicine with distinction and dedication as a member of the Medical Association of Atlanta, Medical Association of Georgia and American Medical Association; and

*Whereas*, he has also been an active and honored member of this House of Delegates of the Medical Association of Georgia; therefore, be it

RESOLVED, that the House of Delegates unanimously express its sincere congratulations to Dr. Louis W. Sullivan for his appointment as Secretary of the U.S. Department of Health and Human Services and extend to him its full support in performing the duties and obligations of this high office.

#### HOUSE ACTION

Adopted with commendation.



*Dr. J. Robert Logan, Chairman of Reference Committee D.*

### RESOLUTION 31

#### National Accreditation of Continuing Medical Education (CME) Providers

#### John A. Goldman, M.D.

*Whereas*, the Accreditation Council for Continuing Medical Education (ACCME) has been charged by the American Medical Association, American Hospital Association and five other national founders to administer an equitable and educationally sound program of approving medical schools, national medical societies and other *national* providers of CME on the basis of their quality; and

*Whereas*, the ACCME has certified state medical associations to accredit *intrastate* CME providers, such as metropolitan hospitals or state specialty societies, on the same basis of quality; and

*Whereas*, the CME programs offered by some "intrastate" providers may reflect the commitment of educational expertise, personnel and other resources so as to equal and possibly surpass the quality of CME programs offered by certain "national" providers; but



Whereas, all "national" providers are accorded greater privileges by the ACCME such as the ability to conduct an indefinite number of nationally-marketed CME programs, while "intrastate" providers are restricted by the ACCME to locally marketed CME programs, regardless of their educational quality; and

Whereas, arbitrary and unfair this distinction between "national" and "intrastate" providers thus forms a

double standard that is fair to neither the educational providers themselves nor the physicians whom they serve to educate; therefore be it

RESOLVED, that the MAG Delegation to the AMA House introduce a resolution calling upon the American Medical Association, as a sponsor of the ACCME, to work with ACCME to eliminate its arbitrary and unfair distinction between national and intrastate providers.

## HOUSE ACTION

Adopted as amended: "that the MAG Delegation to the AMA House introduce a resolution calling upon the American Medical Association, as a sponsor of the ACCME, to work with ACCME to reduce its distinction between national and intrastate providers, while retaining the authority of state medical associations as intrastate accreditors."

## Editorial

(Continued from p. 379)

their way of thinking that it may become a natural step in approaching problems. Even if this use of perspective is not applicable in solving scientific and mathematical problems, it is essential in dealing with human problems whether as individuals or in groups.

**R**elated to this attribute of perspective, is the quality of appreciation or gratitude. In a noble human being, this characteristic takes its place only a little below courage, integrity, and compassion. Indeed, it is related to the latter.

In a culture where the contemporary or the present is exalted, it is easy to disparage the importance of the past. The epigram, "The Past is only Prologue" becomes "The Past is Irrelevant." Arrogance and egotism thrive in such a climate. The self-made person claims too much. He minimizes, or forgets altogether, those persons and circumstances which played a part in the success of which he boasts. It is hard to be completely self-centered when one surveys the circumstances of his situation and keeps his perspective.

Viewed in this light, the observance of anniversaries such as centennials and bicentennials should play an important role in

our public life similar to that which birthdays play in our private lives. Such observances should not encourage a worship of the past but should use the recollections of the past to nurture appreciation of those who made the present possible.

On the national level, these celebrations should recall the struggles and sacrifices of forebears in order that we might appreciate the rights and freedoms which we too easily take for granted. They should also inspire us to dedicate ourselves to the preservation of our heritage to be passed on to succeeding generations. These celebrations should not encourage mindless chauvinism or hero worship, but honest understanding of the contributions of our forefathers, with all of their shortcomings as well as their virtues.

Likewise, from a personal point of view, recalling the efforts of parents and grandparents should inspire a sense of appreciation of their struggles to meet the challenges of their day and generation. Their lives may or may not have been heroic, but they bear testimony to the spirit with which succeeding generations should or should not face the problems of their day.

To know something of the lives of those who preceded us helps us understand who we are, but equally as important, it should nurture in us that admirable human quality of appreciation.

Mere knowledge, even of history, does not guarantee all the noble qualities of character, but it should help nurture the trait of gratitude. It may help us understand why we should be grateful and even inspire us to say "Thank You!" — two words hard for some to utter, but essential for rich human relationships.

If a student could conclude the formal study of history with the seeds planted for developing perspective and appreciation, he or she would have made a start toward a richer and better life. In this way, the study of history may be more useful than it first appears.

In the years following the conclusion of formal study, many persons change their attitude toward history as they find interests in architecture, genealogy, biography, or other areas of human endeavor. Discovering that exploration of the past can be more than memorizing facts, many become avid students of the subject they once dreaded. Reading of this nature can inspire or nurture the traits of perspective and appreciation in mature readers, perhaps even more than it can in students. A lifetime experience in learning can continue to enrich the quality of life in a person who resolves not to quit reading when it is no longer assigned. History is more than a subject for schools. It is a record of the human past to be explored as long as one lives.

# Report

## Reference Committee

F

### TREASURER'S REPORT

**Cyler D. Garner, M.D.,  
Treasurer**

**R**eference Committee F was comprised of the following physicians: H. Duane Blair, Chairman, DeKalb; Alva Louie Mayes, Jr., Vice Chairman, Bibb; Alan Plummer, Medical Association of Atlanta; Donald H. Campbell, Cobb; Walter M. Ligon, Cobb; and Ellis H. Nelson, Richmond.

**I**n each year's Treasurer's Report since I took office in 1984, I have emphasized MAG's progress toward achieving organizational goals. Again I mention the importance of a strong financial base needed to assure your Association's ability to fulfill membership needs.

During my term in office, we have rebuilt the cash reserves from practically nothing in 1984 to the present comfortable level. This improved financial stability of the medical association was made possible with only modest increases of dues over the past six years coupled with increased control of expenses. I am pleased to report that the recommendations for fiscal year 1990 propose a balanced budget without a dues increase.

Last year we planned on exploring sources of non-dues income. As a result of these efforts, we have a proposal from MAG mutual for a

guaranteed \$175,000 in revenue in return for MAG's endorsement of their life, disability, and health insurance policies. The proposed budget includes a net gain of \$125,000 (\$175,000 from the endorsement offset by the loss of \$50,000 in revenue from co-sponsoring MAG Mutual's risk management seminars).

During the coming year, we plan to evaluate administrative services. Our first priority will be to develop a long-term strategy for data processing that better meets our needs while minimizing costs. The word processing system which runs on the mini-computer barely supports our workload with present staff levels. Currently, with ten word processing work stations and the accounting system running at the same time, the computer overloads, dropping response time to an unacceptable level. Better and more timely management reports of budget versus actual expenditures are needed too for both day-to-day control and presentations to the Executive Committee and Board of Directors. The present accounting system does not use budget figures and requires significant manual effort before actual figures for the fi-



financial statements can be generated. We want a user-friendly accounting system which gives current expenditures, outstanding commitments, and budget to actual comparisons.

Dues income increased by more than anticipated in fiscal year 1989. This was due to increased membership, and improved delinquency collection procedures instituted in March 1989. We have projected only a modest increase in dues income for FY 1990.

Expenditures for FY 1988 were projected based on actual expenditures as of March 31, 1988. This is more precise than previous estimates, and should make the final expenditures in FY 1990 more closely reflect the proposed budget. Since the accounting system will be tied into the budget during the coming year, the budgeting process should be even more accurate next year.

Reflecting this new revision, as well as examining MAG's needs, several expenditures are budgeted at a substantially higher level than last year. The Legislative Committee and the Physician Involvement Program budgets were interchangeable in past years. This year the PIP was reduced to indicate actual expenditures, while non-PIP legislative expenses were put into the Legislative Committee budget. The rest of the increase is simply a reflection that the new team work approach to legislation involves three lobbyists (rather than one), and includes other staff members and physicians from time to time.

The Finance Committee also recommends a substantial increase in the Public Relations Committee budget. The Public Relations Committee, in conjunction with the Senior Citizens Ad Hoc Committee, recommended a very large public relations/patient education program that would include brochures for patients and a hot-line available to aid senior citizens. In light of the

current Medicare reimbursement problems and the legislative threat of mandatory assignment, the Committee felt this was a most important expenditure on behalf of MAG's physicians.

Finally, the *Journal* budget was increased by about \$32,000 over last year to reflect higher printing costs. Part of the printing costs were increased because of the comprehensive coverage in the proceedings' issue, which increased that issue's number of pages and thus the cost. It should be noted that the proceedings' issue that was listed as a separate item under membership, was not funded separately this year and will be dropped as a line item in next year's budget.

The Finance Committee reduced the requested budget of the Impaired Physicians Program from \$50,150 to \$6,150. The Committee has yet to hire a director, indicate where future revenues will come from, or show that a volunteer physician program will not work. The Finance Committee supported budget recommendations of the Impaired Physicians Committee that dealt with travel and miscellaneous expenses.

During the coming year, the Finance Committee will examine every item in the budget. Some, like the proceedings' issue, were put in years ago for a reason that no longer exists. There are several inactive committees or line items that also need to be examined. While major changes will probably not be made, there will be some improvements made to reflect the ever-changing structure of MAG.

This budget reflects a prudent fiscal plan for MAG. It places money in reserves for future equipment and building needs. It recognizes moderate revenue increases over this year, and revenue that is attainable. It successfully continues my goals of making MAG financially stronger every year while I am your Treasurer. And finally, it allows us to con-

tinue to grow with a balanced budget and without a dues increase.

## Recommendations

1. In view of MAG's strong financial position, a dues increase should *not* be required during FY 1990.

2. It is recommended that \$20,000 be budgeted for Board Contingency as reasonably anticipated expenditures. This is recognition of the fact that the Board has the authority to expend up to 10% of the value of unobligated assets of the Association (approximately \$230,000) should unforeseen circumstances arise.

3. It is recommended that funding for the Impaired Physician Program be set at \$6,150 for travel to District/County meetings, Auxiliary meetings, educational and intervention work and for administrative support expenses.

4. It is recommended that a balanced Fiscal Year 1990 Budget be submitted to the House of Delegates.

## HOUSE ACTION

Adopted the budget with the provision made by the Reference Committee as follows: "It is noted that a marked reduction in funds for the disabled doctors [Impaired Physicians] program has been made in the budget. After considerable testimony concerning the need for continuation of this program and the desirability of a medical director to head the program, the Committee recommends that a medical director of the disabled doctors [Impaired Physicians] programs be hired when an acceptable applicant can be found.

"We further recommend that the Board of Directors fund such a position from the reserves of MAG until the next session of the House of Delegates at which time appropriate permanent funding can be budgeted."

## CHAIRMAN OF THE BOARD OF DIRECTORS

William C. Collins, M.D.

Presented below is the Fiscal Year 1989-1990 MAG Budget as recommended by the Board of Directors:

### BUDGET SUMMARY

Category	Projections May 31, 1989	FY 1989 Budget	FY 1990 Recommended Budget
<b>REVENUE</b>			
Dues Revenue	\$1,969,746	\$1,842,000	\$2,023,746
Risk Management	20,000	50,000	0
Advertising Revenue	115,000	105,600	105,000
Scientific Assembly	43,323	42,500	42,500
Leadership Conference	22,470	15,000	20,000
Journal Subscriptions	3,500	5,000	3,500
AMA Refund	10,211	8,500	20,992
Data Processing	6,383	15,000	8,000
Interest Income	85,000	72,000	88,000
Rental Income	33,000	18,500	33,000
Miscellaneous Income	86,819	46,000	195,000
<b>Total Revenue From Operations</b>	<b>\$2,395,452</b>	<b>\$2,220,100</b>	<b>\$2,539,738</b>
<b>EXPENDITURE SUMMARY</b>			
Administration	\$1,088,625	\$1,078,387	\$1,236,955
Membership Services	156,831	167,925	192,570
Building	175,437	184,000	188,500
Journal	218,316	195,368	230,649
Data Processing	151,584	170,860	165,640
Other	3,600	3,600	6,400
Board Contingent	10,000	20,000	20,000
Committees	436,203	393,640	499,024
Allocation from Tort Reform	(75,000)		
<b>Expenditures Regular Operations</b>	<b>\$2,165,596</b>	<b>\$2,213,780</b>	<b>\$2,539,738</b>
<b>Revenue Over Expense Regular Operations</b>	<b>\$229,856</b>	<b>\$6,320</b>	<b>\$0</b>
<b>ADMINISTRATION</b>			
Salaries	\$703,416	\$675,737	\$795,517
Health Insurance	33,516	52,500	56,603
Disability Insurance	3,021	4,200	3,173
FICA Tax	35,343	51,250	50,352
Unemployment-State	1,484	1,450	1,703
Unemployment-Federal	1,096	1,300	1,106
Retirement	55,856	53,400	56,201
Recruitment	4,962	800	800
Legal Fees	12,000	15,000	15,000
Telephone	40,100	51,000	42,000
Postage	37,468	49,000	45,000
Staff Travel	43,467	32,000	45,000
Printing	5,601	2,500	7,000
Dues & Subscriptions	10,274	8,500	9,000
Audit, Tax & Payroll	24,863	30,000	30,000
Equip. Maintenance & Xerox	21,235	19,250	22,000
Pension Administration	2,500	4,500	2,500
Consulting & Temporary Help	29,667	3,500	30,000
Office Supplies	22,756	22,500	24,000
<b>Total Administration</b>	<b>\$1,088,625</b>	<b>\$1,078,387</b>	<b>\$1,236,955</b>



# Reference Committee F

Category	Projections May 31, 1989	FY 1989 Budget	FY 1990 Recommended Budget
<b>BUILDING</b>			
Building Maintenance	\$14,571	\$11,000	\$18,500
Janitorial Service	16,632	18,000	18,000
Insurance	13,919	15,000	15,000
Utilities	36,211	41,000	38,000
Depreciation — Building	31,360	32,000	32,000
Depreciation — Equipment	32,000	32,000	32,000
Ad Valorem Tax	30,744	35,000	35,000
<b>Total Building</b>	<b>\$175,437</b>	<b>\$184,000</b>	<b>\$188,500</b>
<b>MEMBERSHIP</b>			
Travel — President	\$17,898	7,000	\$15,000
Travel — President-Elect	6,128	4,000	6,000
Travel — Past President	5,327	3,000	6,000
Travel — AMA Delegates	31,964	35,000	47,000
Caucus Breakfast	1,733	2,600	2,500
Headquarters Suite	5,000	10,000	5,000
Southeaster Coalition	2,018	4,000	2,000
Travel — Sec. & Treas. to AMA	977	3,500	3,500
Two MD's AMA Leadership	0	1,800	0
AMA — Medical Student Section	5,643	10,850	16,070
State Medical Education Luncheon	0	375	0
Sundry	0	600	0
Executive Committee Provisional	7,444	6,000	7,500
Executive Committee Travel	6,945	8,700	7,000
Meetings	14,625	11,000	15,000
President Provisional Fund	24,000	24,000	24,000
President Executive Fund	6,112	16,000	14,000
Roster	21,017	16,500	22,000
Proceedings Issue	*	3,000	*
<b>Total Membership</b>	<b>\$156,831</b>	<b>167,925</b>	<b>\$192,570</b>
<b>JOURNAL</b>			
Salaries	\$42,500	47,650	\$45,250
Health Insurance	2,916	5,625	3,746
Disability	207		222
FICA	2,816	5,830	3,398
Unemployment — State	178		129
Unemployment — Federal	119		84
Retirement	2,935	3,040	3,620
Printing	130,000	108,000	135,000
Photo Processing	1,611	500	1,500
Advertising Promotion	5,156	500	2,000
Postage	16,088	14,773	16,000
Clipping Service	576	450	300
Dues & Subscriptions	545	300	400
Consulting Services	5,501		10,000
Artwork	4,948	6,500	6,500
Travel	2,220	2,200	2,500
<b>Total Journal</b>	<b>\$218,316</b>	<b>195,368</b>	<b>\$230,649</b>

\*Projected 5/31/89 and 1990 Budget including in *Journal* printing.

# Reference Committee F

Category	Projections May 31, 1989	FY 1989 Budget	FY 1990 Recommended Budget
<b>OTHER</b>			
Franklin/Woody Benefits	\$3,600	\$3,600	\$6,400
Board Contingent	10,000	20,000	20,000
<b>Total Other</b>	<b>\$13,600</b>	<b>\$23,600</b>	<b>\$26,400</b>
<b>DATA PROCESSING</b>			
Salaries	\$55,000	\$58,000	\$60,000
Health Insurance	5,707	4,000	7,155
Disability Insurance	267	360	294
FICA	4,131	4,360	4,506
Unemployment — State	229	190	173
Unemployment — Federal	141	170	112
Retirement	3,067	3,200	4,800
Insurance	717	1,500	800
Equipment Rental	4,541	1,500	1,500
Equipment Maintenance	25,261	27,500	26,000
Data Communication	226	780	500
Supplies	9,178	6,000	8,500
Depreciation/Amortization	37,379	48,000	40,000
Travel	43	1,500	1,500
Education & Dues	278	300	300
Consulting Fees	0	5,000	4,000
Office Operations	5,419	6,500	5,500
Documentation	0	2,000	0
<b>Total Data Processing</b>	<b>\$151,584</b>	<b>\$170,860</b>	<b>\$165,640</b>
<b>COMMITTEES</b>			
Access to Health Care	\$2,000	\$2,000	\$2,100
Annual Session	38,000	38,000	38,000
Auxiliary	64,878	66,638	75,379
It's Up to Youth — Auxiliary			10,000
Doctor-of-Day	8,431	7,000	8,500
Impaired Physicians	0	29,167	6,150
Legislation & Bulletin	127,500	70,000	125,000
Physician Involvement Program	2,500	10,000	2,700
Education	2,163	2,825	2,825
Medical Aspects of Sports	945	1,200	1,500
Physicians-Lawyer Liaison	0	2,000	4,000
Membership Insurance	0	1,500	0
Public Relations	77,311	60,000	115,000
Scientific Assembly	31,573	40,000	35,000
Newsletter	27,832	24,900	26,400
Third Party Relations	16,874	2,500	2,500
Leadership Conference	12,695	15,000	15,000
Resident Physician Section	1,142	3,205	6,030
Young Physician Section	0	3,205	8,740
Public Health	18,744	5,000	3,000
Medical Schools	1,352	1,000	1,000
Membership	1,283	3,000	4,000
Medical Practice	0	0	1,200
Hospital Medical Staff	0	0	5,000
Committee on Disadvantaged	0	3,000	0
Professional Liability Support	980	2,500	0
<b>Total — Committees</b>	<b>\$436,203</b>	<b>\$393,640</b>	<b>\$499,024</b>
<b>BUILDING RESERVE EXPENDITURES</b>			
Paint Offices			\$9,582
Carpeting			33,568
			<b>\$43,150</b>



## SUPPLEMENTAL REPORT

### Reserve For Tort Reform Activities

As of May 31, 1988, the audited balance in the Tort Reform Reserve Account was \$540,023. The only direct expenditure this year was for the tort reform survey of obstre-

tricians, gynecologists, and family practitioners. A special \$75,000 charge was authorized by the 1988 House of Delegates to offset salaries expended for efforts during FY 1989 to enhance Tort Reform legislation. There are no current plans to expend substantial amounts from this reserve. A summary of the reserve since its inception and projected May 31, 1989 balance follows:

	FY 1987 (Audited)	FY 1988 (Audited)	FY 1989 Projected
Balance at Beginning of Year	\$0	\$479,652	\$540,023
Membership Assessments	888,544	32,511	
Interest Income	31,238	29,699	35,000
Expenses	(440,130)	(1,839)	(7,254)
Charged authorized by 1988 House of Delegates			(75,000)
Balance at End of Year	\$479,652	\$540,023	\$492,769

## SENIOR CITIZENS ADVOCACY COMMITTEE

Joe L. Nettles, M.D.,  
Chairman

Refer to Report of Reference Committee B for the complete report of the Senior Citizens Advocacy Committee.

### Recommendations

After further discussion, the Committee agreed to recommend that:

1. MAG urge physicians to continue to see Medicare patients and help them deal with current or ongoing problems with Medicare. (Referred to Reference Committee B.)

2. MAG educate physicians and senior citizens about changes in the

Medicare program and the potential impact of these changes on the physician and the beneficiary. (Referred to Reference Committee D.)

\* 3. A patient information brochure developed by the Indiana Medical Association, entitled "Medicare: What you should know," be revised for distribution in Georgia.

\* 4. An easily revised fact sheet regarding Medicare be prepared.

\* 5. A hotline for Medicare patients be established in MAG headquarters on a one-year trial basis.

6. MAG pursue the feasibility of developing voluntary medical care and/or Medicare participation programs for those senior citizens living at or below 150% of the Georgia poverty level.

7. Representatives of the AARP and other appropriate agencies be

invited to participate in the development of the education process. (Referred to Reference Committee D.)

\*Fiscal Note: Funds included in Public Relations Committee Budget.

## HOUSE ACTION

Recommendations 3, 4, and 5 were adopted.

Recommendation 6 was referred to the Board of Directors.

## PUBLIC RELATIONS COMMITTEE

Jeffrey T. Nugent, M.D.

1. MAG Healthy Lifestyles Campaign — "A Prescription For Life":

At the 1988 Annual Meeting of the Medical Association of Georgia House of Delegates, the Public Relations Committee recommended that our major public relations project for 1988-89 be Healthy Lifestyles, a comprehensive program of public education with grass roots involvement of county medical societies. In its final action, the House of Delegates approved our recommendation and our budget.

The overall objective of this campaign is to promote healthy lifestyle choices among Georgians in an effort to improve physical fitness and healthy eating habits, as well as decrease the use of alcohol, tobacco and drugs and to lessen stress. The long term goal of the campaign is to position physicians as experts in helping Georgians make the right healthy lifestyle choices.

Over the course of the year, the Public Relations Committee projected four patient brochures covering the topics of *fitness, addiction, driving safety, and stress*. The



brochures were mailed to physicians' offices and county medical society and auxiliary leadership. In addition, the Public Relations Committee produced a 30 second television public service announcement which received a Merit Award from *Health Care Marketing Magazine*.

MAG spearheaded a wellness consortium created by WPBA, Channel 30 in Atlanta. The station produced a show entitled "Health-style" which aired every Wednesday from 6:00-6:30 p.m. MAG's major role was to assist in the development of program topics and provide physician panelists for each show. Program topics included: healthy lifestyle habits, AIDS, infertility, elderly care, children, cosmetic surgery, health care costs and chronic health problems.

The Public Relations Committee designed a leadership packet for county medical societies and auxiliaries containing a series of twenty-four pre-written 60 second public service announcements for local physicians and auxiliaries to read on the air.

A 40-minute video on adolescent topics such as AIDS, teen suicide, teen sex, cheating, and parental drug use was developed for use in Georgia schools. The title of the video is "Scenarios." The co-sponsor was the Georgia Hospital Association. Mr. Mark Schenker produced this document in conjunction with Mrs. Sherry W. Marsh and members of the Public Relations Committee. The video tape was shown to the teenagers attending the Teen Health Forum ("IT'S UP TO YOUTH") at the Tate Student Center at the University of Georgia on March 14, 1989. One hundred copies of the video tape have been made and distributed to county medical societies, auxiliaries and schools participating in the Teen Health Forum.

The Teen Health Forum targeted over 700 students from numerous high schools within a two hour ra-

dius of Athens, Ga. This extremely important and successful project under the leadership of Mrs. Connie Menendez, Mrs. Barbara Tippins and Mrs. Jan Collins, President of the Auxiliary of the Medical Association of Georgia was a truly outstanding event and bears repeating in other parts of the state.

## 2. Tort Reform Survey of Obstetricians, Gynecologists, and Family Practitioners

A comprehensive survey was initially developed by MAG staff, and after consultation with the leadership of the specialty societies and the Data Tabulating Service, Inc. of Atlanta, Georgia, questionnaires were mailed to 1300 physician members of the Medical Association of Georgia on January 30, 1989. A total of 584 physicians completed and returned the survey. By specialty, this total was made up by 220 OB/GYNs, 57 GYNs, 211 family physicians and 52 physicians who did not define their specialty and 44 physicians who were not in current practice. Valuable information was learned from this survey, the most important being that 51% of the responding physicians said that they had discontinued OB services or planned to do so.

Results of the 1989 survey will be used in our preparations for further reform in the 1990 Georgia General Assembly. The Public Relations Committee wishes to work with the Tort Reform Committee in developing further materials and a plan for action.

## 3. Proposed Medicare Education Program

During this year the Public Relations Committee has worked with the Senior Citizen Advocacy Committee to reach a consensus as to the direction to be taken for obtaining grass roots involvement of patients to help in Medicare reform. It was agreed at a meeting of the Senior Citizen Advocacy Committee in January of 1989 that the general program designed by Dr. Bill Waters of Atlanta, entitled project "TIP" (To

Inform the Public), should be considered for implementation in 1989-90.

A proposed public awareness effort would include (1) informing patients of their rights under Medicare, (2) educating patients as to certain forms of disenfranchisement present in the Medicare rules and regulations; and (3) suggested solutions. With government intervention becoming ever more rampant with regard to the physician/Medicare patient relationship, determination of "unnecessary" tests and treatment, refusal to pay for important preventive medical services, etc., MAG should cooperate with other senior citizen advocacy groups in promoting this project.

## 4. Proposed Medicare Public Education Program Components

A. A pamphlet to educate doctors in the State of Georgia about the need for education of Medicare beneficiaries.

B. Patient information sheets similar to that developed by the Indiana Medical Association, entitled "Medicare: What You Should Know" will be developed for distribution in the State of Georgia.

C. A booklet describing in more depth specific elements of the Medicare program which need reform thereby leading to action by the recipient in the form of personal contact with U.S. Senators or Representatives.

D. A telephone HOTLINE for Medicare patients should be established in MAG headquarters.

E. Consider publishing an "open letter" to people of Georgia in major news media.

F. The feasibility of developing voluntary Medicare participation programs for beneficiaries living at or below 150% of the Georgia poverty level should be investigated.

G. MAG representative should initially contact representatives of the AARP and other appropriate senior citizen agencies for development of this project. The Public Relations Committee would work with the



Senior Citizens Advocacy Committee, the Executive Committee of the Medical Association of Georgia and the AMA in developing policy and direction for this project.

A proposed budget of \$100,000 for the Medicare public education program will essentially be divided as follows: \$50,000, for printed materials; \$10,000, for public relations consultant; \$40,000, for HOTLINE, speakers bureau, slide show presentation.

#### 5. Other Activities of the Public Relations Committee

A. Following the House of Delegates meeting in April of 1988, our Committee distributed news releases concerning key house actions throughout the state.

B. The PR staff responded to county medical society requests by drafting letters and editorials for publication in local newspapers.

C. The PR staff assisted the MAG Mutual Insurance Company in scheduling educational programs across the state on the new Informed Consent Law.

D. The PR staff filled a request from *KNOW ATLANTA* magazine to write an article on how to select a physician. The magazine is targeted at newcomers in Atlanta.

E. The Committee and staff continue to field calls from the public and the medical community such as Relative Value Scale, Medicare, AIDS, and Tort Reform.

MAG's Public Relations Committee met three times in 1988-89, and the Chairman wishes to thank the members of the Committee who gave a great deal of their time and energy to our projects during this past year:

Sheldon B. Cohen, M.D., Atlanta; Mrs. William C. Collins, Atlanta; Kathy Easterling, M.D., Atlanta; James G. Killebrew, Jr., M.D., LaGrange; Thomas A. Lyons, M.D., Athens; Charles W. McDowell, Jr., Decatur; Toby S. Morgan, M.D., Rome; Alan Pomerance, M.D., Tucker; Beverly B. Sanders, Jr., M.D., Macon; Joseph W. Stubbs, M.D., Albany; Wil-

liam Weston, M.D., Augusta; Edgar Woody, M.D., Atlanta; Nathan Se-gall, M.D., Atlanta; John Bostwick, III, M.D., Atlanta; and Gerald M. Stapleton, M.D., Austell.

#### Recommendations

1. That the major public relations project for 1989 be Medicare public education in Georgia, consisting of a comprehensive program designed to inform patients of their rights and duties concerning Medicare. This will be carried out in coordination with the Senior Citizen Advocacy Committee, the MAG Executive Committee, and the AMA.

2. That the Public Relations Committee requests of a total of \$115,000.00 be adopted as set out below:

Medical Education Program	\$100,000.00
Reprints of educational materials (Healthy Lifestyles, AIDs campaigns)	7,000.00
Travel, clipping service and administrative services	4,000.00
400 additional reprints of adolescent videotape for delivery to schools in Georgia	4,000.00
<b>TOTAL</b>	<b>\$115,000.00</b>

#### HOUSE ACTION

Adopted.

### RESOLUTION 2

#### Financial Structure of the JMAG

#### Cobb County Medical Society

*Whereas, the Journal of the Medical Association of Georgia has through the years proven to be a*

valuable and indispensable means of communication with the membership of the MAG; and

*Whereas, the JMAG over the recent past has continued to provide a vehicle for the publication of scientific and socioeconomic articles prepared by the membership of MAG; and*

*Whereas, the JMAG has over the recent past demonstrated continued ability to respond to the needs of the membership of the organization, continuing to represent a valuable means of communication with the membership; and*

*Whereas, the operating budget of the JMAG has not been increased over the past several years in the presence of an ever-increasing production budget; now, therefore, be it*

**RESOLVED**, that the financial structure of the *Journal of the Medical Association of Georgia* be carefully reviewed by this Annual Session of MAG with a view toward more realistic and equitable budgeting for the publication; and be it further

**RESOLVED**, that the amount attributed to the JMAG from membership dues be raised from \$10.00 to \$20.00.

#### HOUSE ACTION

Resolutions 2 and 15 both pertained to JMAG and were considered together. Resolution 15 adopted.

### RESOLUTION 15

#### Allocation of MAG Dues for JMAG

Georgia Medical Society

*Whereas, the Journal of the Medical Association of Georgia serves as an indispensable medium of communication with the membership of the Association; and*

Whereas, the JMAG has for many years subsisted with a designated \$10.00 per member relegated to the cost of production of the *Journal*; and

Whereas, the production costs of the JMAG have risen in concert with inflationary factors over the past many years; therefore be it

RESOLVED, that \$20.00 of each member's dues paid to the MAG be recognized as a fair and reasonable contribution toward the production costs of the JMAG, and that this increase in the JMAG budget does not infer any intent to increase the total amount of individual dues.

### HOUSE ACTION

Resolutions 2 and 15 both pertained to JMAG and were consid-

ered together. Resolution 15 was adopted.

---

## RESOLUTION 43

### Battered Women

**Teresa E. Clark, M.D.**

**Luella Klein, M.D.**

**R**efer to the Report of Reference Committee C for the full report to Resolution 43.

RESOLVED, that the Medical Association of Georgia (MAG) commend ACOG for its leadership in educating physicians regarding recognition and care of battered

women; and be it further (*Referred to Reference Committee C.*)

RESOLVED, that the MAG further these efforts by disseminating to its members information on recognition and treatment of battered women including statewide referral support systems at a cost of \$4600 for 6500 bulletins; and be it further

RESOLVED, that the MAG support in concept legislative efforts to address this problem. (*Referred to Reference Committee C.*)

### HOUSE ACTION

Adopted second RESOLVE and referred to the Board of Directors for funding and implementation.





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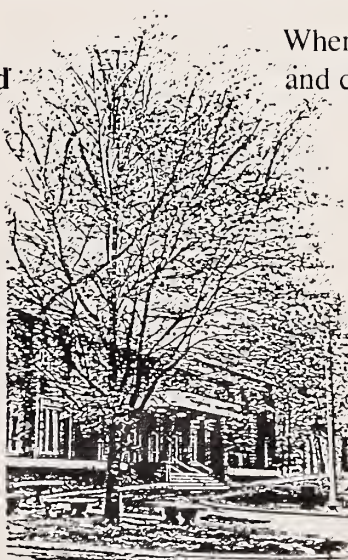
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# Report

## Reference Committee

# C&B

### COMMITTEE ON CONSTITUTION AND BYLAWS

**J. Rhodes Haverty, M.D.,  
Chairman**

**T**he Reference Committee on Constitution and Bylaws was comprised of the following physicians: Joy A. Maxey, Chairman, DeKalb; James F. Beattie, Vice Chairman, Walker-Catoosa-Dade; John T. Yauger, Medical Association of Atlanta; E. M. Molnar, Muscogee; Joe C. Stubbs, South Georgia; Luther M. Thomas, Richmond; and Rodney L. Smith, Hall.

**T**he Committee on Constitution and Bylaws submits this report for the consideration of the House of Delegates. The Committee met prior to the convening of the House to study, review and make recommendations concerning several constitutional amendments that have laid on the table since our last Annual Session and are, therefore, now eligible for consideration by the House. Several more Constitutional amendments have been introduced this year, however they cannot be voted on until the 1990 Annual Session. Numerous Bylaws amendments have been properly referred to the Committee in compliance with Chapter XVI of the Bylaws. This report will discuss each of the various amendments presented for consideration.

First, the actions pending from the 1988 Annual Session will be discussed. This 1988 Reference Com-

mittee on Constitution and Bylaws recommended and the House concurred that the issue of deleting the "Associate Member" category should be sent to this Committee for further study. There currently are approximately 63 Associate members. This category was originally established to recruit residents and interns. It is based upon a reduced membership fee. At present many Associate members are members of the Georgia State Medical Association. After much deliberation, the Committee felt that at present no action should be taken on changing this membership category.

The Committee also took under consideration a request of the Chairman of the Board to allow for the size of the Finance Committee to be increased from its current 3 members. The Committee agreed that such a change is needed and Resolution 40 is therefore submitted by this Committee with a do pass recommendation.

The Report of the Secretary (Officer: 2/88) called for the creation of another membership category to be designated as an "at-large" membership category. The concept is to provide a mechanism for





*Members of the Reference Committee on Constitution & Bylaws (C&B) included (L to R) Joe Stubbs, Luther Thomas, John Yaeger, E. M. Molnar, Rodney Smith, and James Beattie.*

membership in MAG for physicians that have their dominant practice in a county that does not have a properly chartered component county society. There are several counties that fall into this category on a regular basis for failure to maintain a minimum of 5 members or for failure to hold a meeting and elect officers. During its study of this issue, the Committee discovered that both the Constitution and the Bylaws would have to be amended to permit physicians to be members of MAG without belonging to a component county society. After considerable debate, but in accordance with the Report of the Secretary, the Committee prepared Resolution 44 containing both amendments to the Constitution (Article IV, Section 2) and the Bylaws (Chapter II, Section 1 (a) (iv)). This Resolution will have to lay on the table until the 1990 House meets.

The Committee points out that Chapter VIII, Section 9 currently provides for a method for a physician to join an adjacent component county society, but acknowledges the reluctance of physicians to join across the county boundaries. This

Committee, however, recommends that Resolution 44 do pass.

The Committee also studied a proposed amendment to Article V — House of Delegates, Section 1. Composition. The proposed amendment would delete the Hospital Medical Staff Section from the Constitution, thus removing that Section's representation from the AMA Section meeting and from the MAG House of Delegates. Even though the 1988 Reference Committee D supported passage of the change, the Committee on Constitution and Bylaws recommends that this amendment found in Resolution 36 do not pass.

The 1988 Annual Session also took up the question of specialty society representation at the House of Delegates. Your Committee on Constitution and Bylaws recommends that those specialty societies that are recognized by MAG's Committee on Specialty Society Relations should be permitted to have a voting Delegate in the House of Delegates. Accordingly the Committee recommends that Resolution 41 containing an amendment to Article V of the Constitution and Chapter IV, Section 2 (c) do pass.

The Committee also recommends that the criteria for specialty society approval be reviewed and revised. Currently there are specialty societies that are approved, yet they have less than the 60% MAG membership required at the time they were officially recognized by the MAG Committee on Specialty Society Relations. This Committee, therefore, recommends that specific language be incorporated into the Bylaws requiring that the Specialty Society have at least 60% MAG membership in order to be entitled to a delegate to the House.

Your Committee presented last year Committee Report 8-A containing proposed Constitutional amendments to Article V — House of Delegates, Article VI — Board of Directors, Article X — Funds and Expenditures and Article XI — Official Publication. The Committee recommends that the 4 amendments found in Resolution 37 do pass. The amendment to Article V allows the Bylaws to determine the number of delegates elected by the component societies. The change in Article VI will allow MAG members who are past presidents of the AMA to be an ex-officio member of



the Board of Directors without the right to vote. Article X is amended by striking the language concerning equal per capita assessment and inserting instead "as determined by the Bylaws." Article XI removes the mandatory requirements concerning official Association notices and House of Delegates activities. This gives the Editor some discretion and may save the Association money.

The Committee additionally considered the following resolutions introduced to the 1989 House and makes the following recommendations:

## SUPPLEMENTAL REPORT OF THE COMMITTEE ON CONSTITUTION AND BYLAWS

**J. Rhodes Haverty, M.D.,  
Chairman**

**T**he 1988 House of Delegates through the adoption of Reference Committee D's report referred a Bylaws amendment to Chapter V,

Section 4. Executive Committee to the Board of Directors for study. The change would add to Chapter V, Section 4 (a) and (b) the following underlined language:

### CHAPTER V — BOARD OF DIRECTORS

#### SECTION 4. EXECUTIVE COMMITTEE

"(a) Composition. The Board of Directors shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the First and Second Vice-Presidents, the Secretary, the Treasurer, the Chairman of the Board of Directors, the Speaker of the House of Delegates and the Vice-Speaker of the House of Delegates, and the Chairman of the Georgia Delegation to the American Medical Association House of Delegates or, in his absence, the Vice-Chairman. The President shall serve as the Chairman of the Executive Committee, and the Chairman of the Board of Directors shall serve as the Vice-Chairman of the Executive Committee.

"(b) Meetings. The Executive Committee shall meet monthly every six weeks between meetings of the Board of Directors, or by the call of the President, but not prior to meetings of the House of Delegates. At any duly called meeting of this Committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum."

The Board of Directors referred the proposed language to the Committee on Constitution and Bylaws for further study and recommendation. Your Committee recommends that the changes found in Section 4 (a) do pass and that the changes found in Section 4 (b) do not pass. Therefore the Committee on Constitution and Bylaws recommends the adoption of the following amendment so that Chapter

<u>Resolution</u>	<u>Amendment</u>	<u>Recommendation</u>
Res: 39 Special Rules of Procedure	Chapter XV, Section 3	DO NOT PASS
Res: 38 Executive Sessions	Chapter II, Section 1(b)	DO NOT PASS
Res: 27 Elimination of Penalty for Reinstatement into Membership	Chapter IX, Section 2(c)	DO PASS
Res: 28 Duties of the Executive Director	Article V, Section 1 Article VI, Section 1	DO PASS DO PASS
(NOTE: Resolution 28 must lay on the table for one year as it amends the Constitution)		
Res: 29 Qualifications for Life Membership	Chapter II, Section 7	DO NOT PASS
Res: 30 Duties of the Executive Director	Chapter IV, Section 5 Chapter V, Section 1(c) Chapter V, Section 5 Chapter VII, Section 5(a) Chapter VII, Section 5(b)	DO PASS DO PASS DO PASS DO PASS DO PASS
Res: 6 Medical Student Member to the MAG Board of Directors	Article VI, Section 1 Article II, Section 8 Chapter V, Section 1(a)	DO NOT PASS DO NOT PASS DO NOT PASS
Res: 7 Medical Student Member to the MAG House committees	Chapter IV, Section 7	DO NOT PASS
Res: 9 Medical Student Section representative as a Delegate to the MAG House of Delegates	Chapter IV, Section 2 (b) (iii)	DO NOT PASS

### HOUSE ACTION

Filed.



V, Section 4 (a) of the Bylaws will read as follows:

"(a) Composition. The Board of Directors shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, the President-Elect, the Immediate Past President, the First and Second Vice-Presidents, the Secretary, the Treasurer, the Chairman of the Board of Directors, the Speaker of the House of Delegates and the Vice Speaker of the House of Delegates, and the Chairman of the Georgia Delegation to the American Medical Association House of Delegates or, in his absence, the Vice Chairman. The President shall serve as the Chairman of the Executive Committee, and the Chairman of the Board of Directors shall serve as the Vice-Chairman of the Executive Committee."

#### HOUSE ACTION

Adopted.

### RESOLUTION 3

#### Committee Chairmanship

**George L. Smith, M.D.**

*Whereas*, to ensure a consistent freshness to the policies of the Medical Association of Georgia; be it

RESOLVED, that any committee chairmanship of the Medical Association of Georgia should not be occupied by the same MAG member more than four consecutive years.

#### HOUSE ACTION

Based on the recommendation of the Reference Committee, this resolution was not considered.

### RESOLUTION 6

#### Student Member of Board of Directors

##### Medical Student Section

*Whereas*, it is a goal of the Medical Association of Georgia Medical Student Section to encourage increased participation in Local/County Medical Societies, the Medical Association of Georgia, and the American Medical Association; and

*Whereas*, the Medical Student Section of the Medical Association contributes to and represents over seven hundred members of the Association; and

*Whereas*, in 1984, the AMA House of Delegates adopted bylaw changes that created a seat for a student member of the AMA Board of Trustees; now, therefore be it

RESOLVED, that the Medical Association of Georgia implement changes in its Constitution and Bylaws to allow for a student member of its Board of Directors; and be it further

RESOLVED, that the student member shall have the right to participate fully in meetings of the Board; and be it further

RESOLVED, that the student member of the Board shall be the Chairperson of the Medical Student Section of the Medical Association of Georgia; and be it further

RESOLVED, that the first sentence, Article IV, Section I of the Constitution be amended to read as follows:

"ARTICLE VI — BOARD OF DIRECTORS

"SECTION I. COMPOSITION. The Board of Directors is composed of the President, the President-elect, the Immediate Past President, the two preceding immediate past presidents, two vice presidents, Secretary, Treasurer, Speaker of the House of Delegates, the Chairperson of the Medical Student Section, and Directors as provided for in the Bylaws."; and be it further

RESOLVED, that the second sentence of Chapter II, Section 8 of the Bylaws be amended to read as follows:

"Unless otherwise provide for in the Constitution or Bylaws, student members may not vote except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees."; and be it further

RESOLVED, that the Bylaws be amended by redesignating subsection "(iv)" as subsection "(v)"; by striking the word "and" immediately before "(iv)"; and by adding a new subsection "(iv)" to Chapter V, Section 1 (a) of the Bylaws to read as follows:

"(iv) the Chairperson of the Medical Student Section; and '(v)' "

#### HOUSE ACTION

Did not adopt.

### RESOLUTION 7

#### Student Members of Committees

##### Medical Student Section

*Whereas*, it is a goal of the Medical Association of Georgia Medical Student Section to encourage increased participation in local/county medical societies, the Medical Association of Georgia, and the American Medical Association; and

*Whereas*, the Medical Student Section of the Medical Association contributes to and represents over seven hundred members of the Association; and

*Whereas*, since 1986 the AMA has had a medical student seat on all AMA councils as well as on the Liaison Committee on Medical Education; and



Whereas, in 1984, the AMA House of Delegates adopted bylaw changes that created a seat for a student member of the AMA Board of Trustees; now, therefore, be it

RESOLVED, that the Medical Association of Georgia change its Constitution and Bylaws to allow for a student member of committees of the House of Delegates; and be it further

RESOLVED, that the student members shall have the right to participate fully in meetings of the Committees with the right to vote; and be it further

RESOLVED, that the student members of the Committees of the MAG House of Delegates shall be chosen by the MAG Board of Directors from nominees submitted to them by the Medical Student Section of the Medical Association of Georgia; and be it further

RESOLVED, that the third sentence of Chapter IV, Section 7 of the Bylaws be amended to read as follows:

"Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in debate, but, with the exception of student members, shall not have the right to vote; provided however, student members shall have the right to fully participate in committee activities and shall have the right to vote."

### HOUSE ACTION

Did not adopt.

## RESOLUTION 9

### Student Section Representative

#### Medical Student Section

Whereas, it is a goal of the Medical Association of Georgia Medical Student Section to encourage in-

creased participation in local/county medical societies, the Medical Association of Georgia, and the American Medical Association; and

Whereas, the Medical Student Section of the Medical Association of Georgia contributes to and represents over seven hundred members of the Association; and

Whereas, since 1986 the AMA has had a medical student seat on all AMA councils as well as on the Liaison Committee on Medical Education; and

Whereas, in 1984, the AMA House of Delegates adopted bylaw changes that created a seat for a student member of the AMA Board of Trustees; and

Whereas, the Medical Student Section is the only section provided for in the Medical Association of Georgia Constitution and Bylaws which does not have voting representation in the House of Delegates; therefore be it

RESOLVED, the Medical Student Section asks the Medical Association of Georgia to adopt changes in the Bylaws to allow the Section a Delegate to the House of Delegates who shall have the right to make motions and vote; and be it further

RESOLVED, that the Section be entitled to one Representative and an Alternate from each Georgia medical school which is accredited by the Liaison Committee on Medical Education, each of whom shall be a member of the House of Delegates, each of whom shall have the right to be heard at meetings; and be it further

RESOLVED, that the voting Delegate be selected by the Section from among these Representatives and Alternates to the House of Delegates; and be it further

RESOLVED, that the second sentence of Chapter IV; Section 2(b) (iii), of the Bylaws be amended and that a new third sentence, each to read as follows:

"The Section shall be entitled to one student representative and an alternate from each of the medical

schools in Georgia which are accredited by the Liaison Committee on Medical Education, each of whom shall be members of the House of Delegates, each of whom shall have the right to be heard at meetings. The Section shall be entitled to one voting Delegate who shall be selected by the Section from the student representatives to the House of Delegates."

### HOUSE ACTION

Adopted.

## RESOLUTION 27

### Elimination of Penalty for Reinstatement into Membership

William G. Whitaker, III,  
M.D.

Charles W. McDowell, Jr.,  
M.D.

Roy W. Vandiver, M.D.  
R.H. Almeroth, Jr., M.D.  
Walker L. Ray, M.D.

Whereas, an active member who fails to pay dues and assessments for one or more consecutive years may be reinstated upon reapplication subject to approval by the respective county medical society and upon payment of the current year's dues and assessments plus the dues and assessments for the year immediately preceding; and

Whereas, the Medical Association of Georgia needs the participation of as many physicians as possible if it is to achieve its goals and objectives; and

Whereas, county medical societies and MAG officers attempting to reinstate previous members have found this penalty to be a significant barrier to the non-member; now, therefore, be it

RESOLVED, that Chapter IX, Section 2(C) of the Bylaws be amended



by deletion of the phrase "the dues and assessments for the year immediately preceding" and addition of the phrase "the payment of any mandatory assessment levied during his last year of membership.", so that when amended Chapter IX, Section 2(C) will read:

"Chapter IX. Funds and Expenditures

"Section 2. Dues and Assessments

"(c) Any member whose dues and assessments to the Association who have not been paid for the annual membership dues year on or before April 1 of that year shall stand suspended. Such member or members may be automatically reinstated provided all dues and assessments are paid no later than December 31 of that year. An active member who fails to pay dues and assessments for one or more consecutive years may be reinstated upon reapplication subject to approval by the respective county medical society and upon payment of the current year's dues and assessments plus ~~the dues and assessments for the year immediately preceding the payment of any mandatory assessment levied during his last year of membership.~~"

#### HOUSE ACTION

Adopted.

### RESOLUTION 28

#### Duties of Executive Director

**William G. Whitaker, III,  
M.D.**

**Charles W. McDowell, Jr.,  
M.D.**

**Gary Botstein, M.D.  
R.H. Almeroth, M.D.  
Walker L. Ray, M.D.**

*Whereas*, the Medical Association of Georgia was founded in 1849

as an organization of physicians, by physicians and for physicians; and

*Whereas*, the Medical Association of Georgia has enjoyed steady growth throughout its 140 year history and has experienced rapid growth over the past few years; and

*Whereas*, this rapid growth has brought about the need for greater flexibility in making personnel changes consistent with the growing and changing needs of the organization; now, therefore, be it

RESOLVED, that Article V, Section 1 of the Constitution be amended by deletion of the words "the Executive Director" so that when amended Article V, Section 1 will read:

"ARTICLE V — HOUSE OF DELEGATES

"SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component societies, the Resident Physician Section, the Young Physician Section, the Medical School Section, and the Hospital Medical Staff Section. All delegates' qualification and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and Chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote; and be it further

RESOLVED, that Article VI, Section 1 be amended by deletion of the words "and the Executive Director" so that when amended Article VI, Section 1 will read:

ARTICLE VI — BOARD OF DIRECTORS

"Section 1. COMPOSITION. The Board of Directors is composed of the President, the President-Elect, the Immediate Past President, the two preceding immediate past president, two vice presidents, Secretary, Treasurer, Speaker of the House of Delegates and Directors as provided for in the Bylaws. Del-

egates and Alternate Delegates to the AMA, Editor of the *Journal*, past presidents other than the three immediate past presidents ~~and the Executive Director~~ shall be ex-officio members of the Board of Directors without the right to vote. Alternate Directors shall be ex-officio member except in the absence of their respective Directors as provided for in the Bylaws. The Vice Speaker shall be an ex-officio member except in the absence of the Speaker as provide for in the Bylaws."

#### HOUSE ACTION

Proposed constitutional amendments in this resolution were received by the House to lay on the table and be presented for a vote at the next session of the House of Delegates.

### RESOLUTION 29

#### Qualifications for Life Membership

**William G. Whitaker, III,  
M.D.**

**Charles W. McDowell,  
Jr., M.D.**

**Roy W. Vandiver, M.D.  
R.H. Almeroth, Jr., M.D.  
Walker L. Ray, M.D.**

*Whereas*, most national specialty organizations place a physician into a dues exempt membership category upon reaching the age of 65; and

*Whereas*, the current Bylaws provide life membership after a physician has been continuously an active, dues paying member for 25 years and reached the age of 70; now, therefore, be it



RESOLVED, that Chapter II, Section 7 be amended by deleting the number 70 and adding the number 65 to the first sentence so that when amended it will read:

"Chapter II. Membership

"Section 7, Life Members

A member in good standing who is 70 65 years of age (on or by January 1 of the current dues year) may be classified as a Life Member and excused from the payment of Association dues and assessments upon application to the Association through the appropriate component county society as follows: the physician's application shall be granted in due course if such member has been continuously an active dues-paying member of this Association for 25 years; the application shall be granted in due court if the physician has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years, provided that the physician has been active dues-paying member of this Association for at least two of those 25 years; the application may be granted upon action of the Judicial Council if the physician has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years but has been an active dues-paying member of this Association for at least one year and less than ten years. . . ."

## HOUSE ACTION

Did not adopt.

## RESOLUTION 30

### Duties of Executive Director

**William G. Whitaker, III,  
M.D.**

**Charles W. McDowell, Jr.,  
M.D.**

**Gary Bostein, M.D.  
R.H. Almeroth, Jr., M.D.  
Walker L. Ray, M.D.**

*Whereas*, the Medical Association of Georgia was organized 140 years ago by adopting its first Constitution which listed the objectives of the organization to be "Advancement of medical knowledge — the elevation of professional character — the protection of the interest of its members" and other objectives; and

*Whereas*, the rapid growth of the Association over the past few years has intensified the need for a more flexible governance to respond to the the changing needs of the organization and to advance the objectives of the profession; now, therefore, be it

RESOLVED, that Chapter IV, Section 5 of the Bylaws be amended by deletion of the sentence "The Executive Director may serve in this capacity upon request of the Secretary" so that when amended, Chapter IV, Section 5 will read:

"Chapter IV — House of Delegates

"SECTION 5. SECRETARY. The secretary of the association shall be the Secretary of the House of Delegates, or in the absence of the Secretary, a delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates. ~~The Executive Director may serve in this capacity upon the request of the Secretary.~~"

RESOLVED, that Chapter V, Section 1 (c) of the Bylaws be amended by deletion of the words "and the Executive Director" so that when amended, Chapter V, Section 1 (c) will read:

"CHAPTER V — BOARD OF DIRECTORS

"SECTION 1. COMPOSITION.

(c) Alternate Directors shall be members of the Board of Directors without the right to vote except in the absence of the Director from their respective Districts. In the case of a District with multiple Directors, any Alternate from the District may vote in the absence of any Director from that same District. Delegates and Alternate Delegates to the American Medical Association, the Editor of the *Journal*, Past Presidents other than the three Immediate Past Presidents ~~and the Executive Director~~ shall be ex-officio members of the Board of Directors without the right to vote." and be it further

RESOLVED, that Chapter V, Section 5 of the Bylaws be amended by deletion of the words "or Executive Director" so that when amended Chapter V, Section 5 will read:

"CHAPTER V — BOARD OF DIRECTORS

"SECTION 5. MEETINGS. The Board of Directors shall meet at the close of the Annual Session to organize. Between the organizational meeting of the Board of Directors and the following Annual Session, the Board of Directors shall meet a minimum of three times, the time and place of such meetings to be determined by the Board of Directors. Special meetings of the Board of Directors may be held on the call of the president, or of the Secretary ~~or Executive Director~~ upon the request of eight or more members of the Board of Directors." and be it further

RESOLVED, that Chapter VII, Section 5(a) of the Bylaws be amended by deletion of the sentence "At the request of the Secretary the Executive Director may serve in this capacity." And by deletion of the words "or upon the Secretary's request, the Executive Director", so that when amended Chapter VII, Section 5(a) will read:



"CHAPTER VII — RIGHTS AND DUTIES OF OFFICERS

"SECTION 5. SECRETARY.

(a) The Secretary and the Executive Director shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary will keep the minutes of their proceedings. ~~At the request of the Secretary, the Executive Director may serve in this capacity. The Secretary, or upon the Secretary's request, the Executive Director shall be Secretary of the Board of Directors and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.~~

and be it further

RESOLVED, that Chapter VII, Section 5(b) of the Bylaws be amended by deletion of the words "and/or Executive Director" so that when amended Chapter VII, Section 5(b) will read:

"CHAPTER VII — RIGHTS AND DUTIES OF OFFICERS

"SECTION 5. SECRETARY.

(b) The Secretary ~~and/or Executive Director~~, under the direction of the Executive Committee of the Board of Directors, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, issue membership cards, and provide for the registration of members at Annual Sessions. The Secretary shall collect the regular per capita assessment from the Association's members or the component societies in accordance with the provisions of CHAPTER IX, SECTION 2 of these Bylaws and shall make all required reports to the American Medical Association."

**HOUSE ACTION**

Adopted.

**RESOLUTION 36**

**Hospital Medical Staff Section**

**Committee on Constitution and Bylaws**

*Whereas*, Reference Committee D recommended to the 1988 MAG House of Delegates adoption of an amendment to Article V of the Constitution regarding abolishment of the MAG Hospital Medical Staff Section, and

*Whereas*, this amendment has laid on the table for one year as required by the Constitution, and

*Whereas*, this amendment was prepared by the Committee on Constitution and Bylaws in compliance with the request of the 1988 Reference Committee D, now therefore be it

RESOLVED, that Article V — House of Delegates, Section 1, Composition be amended to read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed out~~.)

"ARTICLE V — HOUSE OF DELEGATES

"SECTION 1. COMPOSITION. The House of Delegates is composed of delegates, elected by the Component societies, the Resident Physician Section, the Young Physician Section and the Medical Student Section ~~and Hospital Medical Staff Section~~. All delegates' qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote."

**HOUSE ACTION**

Did not adopt.

**RESOLUTION 37**

**Amendments to Articles V, VI, X, and XI of the Constitution**

**Committee on Constitution and Bylaws**

*Whereas*, as a part of the Committee on Constitution and Bylaws' five year mandatory review conducted last year of the Constitution and Bylaws, the Committee proposed the following Constitutional amendments, and

*Whereas*, these amendments were received by the House at the 1988 session, and they have laid on the table as required pending the convening of the 1989 House of Delegates at which time, they will be formally presented for approval or rejection; now, therefore, be it

RESOLVED, that Article V, Article VI, Article X, and Article XI of the MAG Constitution be amended to read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed out~~.)

"ARTICLE V — HOUSE OF DELEGATES

"SECTION 1. COMPOSITION. The House of Delegates is composed of delegates elected by the component societies in such number as determined by the Bylaws; the Resident Physician Section, the Young Physician Section, the Medical Student Section, and Hospital Medical Staff Section. All delegates' qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.



## "ARTICLE VI — BOARD OF DIRECTORS

"SECTION 1. COMPOSITION. The Board of Directors is composed of the President, the President-elect, the Immediate Past President, the two preceding immediate past presidents, two vice presidents, Secretary, Treasurer, Speaker of the House of Delegates and Directors as provided for in the Bylaws. Delegates and Alternate Delegates to the AMA, Association members who are past presidents of the AMA, Editor of the *Journal*, past presidents other than the three immediate past presidents and the Executive Director shall be ex-officio members of the Board of Directors without the right to vote. Alternate Directors shall be ex-officio members except in the absence of their respective Directors as provided for in the Bylaws. The Vice Speaker shall be an ex-officio member except in the absence of the Speaker as provided for in the Bylaws.

## "ARTICLE X — FUNDS AND EXPENDITURES

"Funds for the Operation of the Association shall be raised ~~by an equal per capita assessment on the members of each component society~~ as determined by the Bylaws. The amount of assessment shall be set by the House of Delegates upon recommendation of the Board of Directors. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the Board of Directors. The Board of Directors shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.

## "ARTICLE XI — OFFICIAL PUBLICATION

"The official publication of the Association shall be the *Journal of the Medical Association of Georgia*, ~~in which shall be published all official Association notices, abstracts of transactions of the House of Delegates, and general meetings of the Association, the annual budget,~~

~~complete financial reports as directed by the Board of Directors and abstracts of meetings of the Board of Directors."~~

## HOUSE ACTION

Adopted.

## RESOLUTION 38

### Executive Session

**James Q. Whitaker, M.D.  
Marjorie L. Sugrue, M.D.  
George R. Brahn, M.D.  
James W. Spivey, M.D.  
John J. Vecchio, M.D.**

*Whereas*, all active members should be allowed to attend all executive sessions in addition to the other privileges of membership; now, therefore, be it

RESOLVED, that Chapter II — Membership, Section 1 — Active Members subparagraph (b) of the Bylaws be amended by redesignating commas and by adding after the word "office," and before the word "and" of the second sentence of said subparagraph (b) the following phrase, ", to attend all meetings including Executive Sessions" so that said subparagraph (b) will read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed out~~.)

## "CHAPTER II — MEMBERSHIP

### "SECTION 1. ACTIVE MEMBERS.

"(b) Those members classified under subparagraph (i) and (iii) above shall pay full annual dues and assessments to the Association; and those members classified under subparagraph (ii) above shall pay such dues and assessments as the House of Delegates upon recommendation of the Board of Directors may from time to time determine. All members described in

this Section 1 shall have full privileges of membership, including the right to vote, to hold office, to attend all meetings including Executive Sessions and to receive the *Journal of the Medical Association*, except as expressly set forth in these Bylaws. A physician applying for active membership after July 1 of any year, who is applying for membership in the Medical Association of Georgia for the first time, shall pay one-half of the annual dues set for that particular membership classification. This does not apply to any physician whose due may be reduced under the provisions of the sliding dues schedule."

## HOUSE ACTION

Did not adopt.

## RESOLUTION 39

### Special Rules of Procedures of the House of Delegates and the Board of Directors

**James Q. Whitaker, M.D.  
James W. Spivey, M.D.  
Marjorie L. Sugrue, M.D.  
William A. Bottle, Jr., M.D.  
John J. Vecchio, M.D.**

*Whereas*, there is a need to refine the operating procedures of the House of Delegates and the Board of Directors to insure that both Delegates and Alternates to both the House and the Board be allowed to speak at all meetings of both entities; and to insure that when a call for a vote on the previous question has been brought before the said governing body, that those persons who have already indicated their desire to speak shall be allowed to address the assembly for a maximum of two minutes prior to a vote



on the said motion; now, therefore, be it

RESOLVED, that a new Section 3 be added to Chapter XV — Rules and Ethics of the Bylaws as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### “CHAPTER XV — RULES AND ETHICS

“SECTION 3. — SPECIAL RULES OF PROCEDURES. Discussion of any matter brought before the Medical Association of Georgia Board of Directors or the Medical Association of Georgia House of Delegates shall be allowed as follows: Any Delegate or Alternate Delegate of the House of Delegates and/or any Director or Alternate Director of the Board of Directors wishing to address his respective entity shall be allowed to speak. Should someone call for a vote on the previous question, those persons having already indicated their desire to speak shall be allowed a maximum of 2 minutes to address the assembly prior to the final vote on the issue.”

#### HOUSE ACTION

Did not adopt.

### RESOLUTION 40

#### Increase the Size of the Committee on Finance

#### Committee on Constitution and Bylaws

*Whereas*, the Committee on Constitution and Bylaws was requested by the Board of Directors to study and make recommendations as to the issue of increasing the size of the Committee on Finance; and

*Whereas*, after thorough study, the Committee on Constitution and

Bylaws feels that the Bylaws should be amended to permit the Committee on Finance to increase its size beyond the current limitation of only three members; now, therefore, be it

RESOLVED, that immediately prior to the word “three” that the words “at least” be added to the second sentence of Section 3, Chapter X — Committees of the Bylaws, so that said second sentence upon adoption of this amendment will read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### “CHAPTER X — COMMITTEES

#### “SECTION 3. COMMITTEE ON FINANCE.

... “The Chairman of the Board of Directors shall appoint from among its members a committee of at least three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association”. . .

#### HOUSE ACTION

Adopted.

### RESOLUTION 41

#### Specialty Society Representation

#### Committee on Constitution and Bylaws

*Whereas*, the 1988 House of Delegates had placed before it a proposed Constitutional amendment adding specialty society representation at the House of Delegates, and

*Whereas*, the said proposed amendment has laid on the table for one year as required by the Constitution, and

*Whereas*, in order to implement the proposed Constitutional amendment would require an additional Bylaws change, therefore be it

RESOLVED, that Article V, Section 1 of the Constitution be amended to read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed-out~~.)

#### “ARTICLE V — HOUSE OF DELEGATES

“SECTION 1. COMPOSITION. The House of Delegates is composed of delegates, elected by the component societies, the specialty societies which are represented on the MAG Committee on Specialty Society Relations, the Resident Physician Section, the Young Physician Section, the Medical Student Section, and the Hospital Medical Staff Section. All delegates’ qualifications and terms of office shall be provided for in the Bylaws. The officers, the past presidents of the Association, the Editor of the *Journal*, delegates to the AMA, the Executive Director and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.”

and, be it further

RESOLVED, that Chapter IV, Section 2 of the Bylaws be amended by adding a new subparagraph (c) to read as follows:

#### “CHAPTER IV — HOUSE OF DELEGATES

#### “SECTION 2. COMPOSITION.

“(c) SPECIALTY SOCIETY REPRESENTATION. Specialty Societies represented on the MAG Committee on Specialty Society Relations which have at least 60% of its members who are also members of the Medical Association of Georgia shall be entitled to one voting delegate and one alternate delegate, each of whom must be a member in good standing of the Medical Association of Georgia, and not simultaneously a delegate or alternate delegate from

any component county medical society or Section. They shall be selected by their respective societies from among the membership thereof for a term of three years." and, be it further

RESOLVED, that upon adoption of the amendments proposed herein, that initially one-third of the specialty society delegates and alternates shall be selected for one year, one third for two years, and one-third for three years, as specified by the MAG Board of Directors. Thereafter, all terms shall be for three years.

## HOUSE ACTION

Did not adopt.

## RESOLUTION 44

### Creation of an At-Large Membership Category

#### Committee on Constitution and Bylaws

*Whereas*, there are several component county medical societies that are having extreme difficulty in

maintaining the minimum five (5) members as required by the Bylaws, and

*Whereas*, there is a reluctance on the part of physicians in those areas to join societies in adjacent counties; and

*Whereas*, to allow for the establishment of an "at-large" membership category would require amendments to both the Constitution and Bylaws: therefore, be it

RESOLVED, that Article IV, Section 1 of the Constitution be amended in the 1990 House of Delegates meeting after lying on the table for one year as required by the Constitution to read as follows:

(Note: Amendments by addition are underlined, and amendments by deletion are ~~crossed out~~.)

#### "ARTICLE IV — MEMBERSHIP

SECTION 1. MEMBERS. The members of the Association are the members of the component county medical societies except as exempted by the Bylaws. The Association is composed of Active, Service, Associate, At-large and Honorary members as provided for in the Bylaws. Other types of membership may be provide for in the Bylaws."

and be it further

RESOLVED, that a new Chapter

II, Section 1(a) (iv) be added to the Bylaws as set out below:

#### "CHAPTER II — MEMBERSHIP

##### "SECTION 1. ACTIVE MEMBERS.

"(iv) A physician shall hold the degree of Doctor of Medicine, Doctor of Osteopathy or Bachelor of Medicine or an equivalent degree issued in a foreign country from a medical college acceptable to the Judicial Council of the Association, be licensed to practice medicine in the State of Georgia, and have his/her dominant practice in a county that is not affiliated with a properly chartered component country society. The Judicial Council shall review and approve or disapprove each At-large application to determine if all of the within stated requirements are met, including a determination as to the validity of the charter of a component county society. A member under this subsection shall be designated as a member 'At-large' and shall not be required to join a component county medical society as is required elsewhere in these Bylaws."

## HOUSE ACTION

First RESOLVE: Constitutional amendment accepted by the House to lay on the table to be presented for a vote at the 1990 House of Delegates meeting.

Second RESOLVE: Did not adopt.





Figure 1

## CLINICAL INFORMATION:

Non-meniscal abnormalities are commonly suspected and evaluated by MRI and unexpected non-meniscal abnormalities are commonly demonstrated in the course of MR evaluation for internal derangements of the knee.

**FINDINGS:** Figure 1 is a sagittal image through the lateral compartment of a 15-year-old patient's knee. The subarticular portion of the lateral femoral condyle is affected by low signal alteration containing three rounded areas of higher signal intensity. The findings here are diagnostic of osteochondritis dissecans (straight arrows). Notice the normal adjacent anterior and posterior horns of



Figure 2

the lateral meniscus (curved arrows).

Figure 2 is a sagittal image through the intercondylar midportion of a 19-year-old patient's knee. The tibial insertion of the anterior cruciate ligament is indicated by the arrow. The remainder of the anterior cruciate ligament is totally disrupted and its expected position is occupied by inhomogeneous material of intermediate signal intensity compatible with hemorrhage. The anterior cruciate has been notoriously difficult to evaluate by MRI, but its reliable evaluation is now possible with careful positioning and rescanning of questionable cases.

Figure 3 is a coronal image of the posterior aspect of the knee



Figure 3

of a 33-year-old patient. The arrow indicates a 1.5 cm. ganglion cyst intimately applied to the lateral aspect of the biceps femoris tendon just proximal to the fibular head. The MR study clearly demonstrates the extra-articular and extraosseous nature of this process.

**COMMENT:** MRI has become clearly established for evaluation of internal derangements of the knee. Meniscal evaluation is known to be highly accurate. The cases shown here are meant to demonstrate the efficacy and accuracy of MR evaluation of extrameniscal structures.



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# *Final General Session*

# *Installation Ceremony*

*Saturday, May 6*

**A**S SPEAKER OF THE MAG HOUSE of delegates, Dr. Kaufmann welcomed those in attendance to MAG's second Installation Ceremony. This ceremony was created in an effort to present the Presidents' addresses and the formal installation of officers in a conjoint ceremony, conveniently scheduled for all members, auxiliaries, and guests to witness the transfer of leadership within the Association.

Mrs. Sheila Greene sang a patriotic medley, accompanied on the piano by Mr. Herb Wright.

#### **President's Introduction**

Speaker Kaufmann introduced MAG's outgoing President, Dr. Bailey, with much pride and admiration, as an exceptional leader of this Association over the past year. Through his untiring and dedicated guidance, and the help of his wonderful wife, Pagie, MAG had an extraordinary year in every respect. His courageous leadership on major issues and policies established high standards for the leadership of this Association and left us with a welcome legacy.

Dr. Bailey then introduced his family and friends and made a few closing remarks which follow.

#### **Outgoing Presidential Address**

**T**HIS HAS been a hard and satisfying year. One coupled with many challenges and difficult solutions.

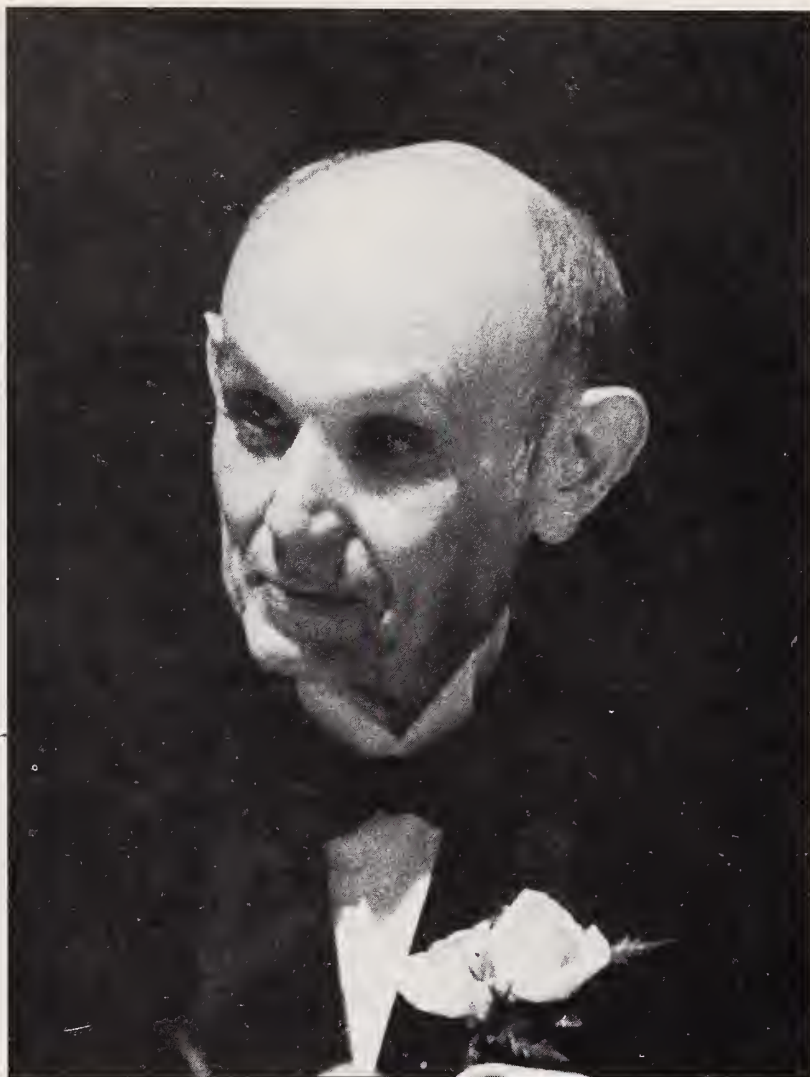
But surely that is the stuff of life. It is great and wonderful to have been in your service as President of the Medical Association of Georgia. Always there is a nagging voice, however, saying "Could you have done more?" or "Could you have done better?" There is an Irish ballad, part of which states "what's won is won, what's done is done, and what's lost is lost and gone forever."

The results of our decisions in medicine do create such conditions. But thank God we are benefited by intelligent and committed minds dedicated to unselfish principles. We are part of a profession which is the highest calling on this



earth — one committed to giving to our fellow human beings. We do have pride in our accomplishments and in our goals — and rightly so. There is no more greatly controlled profession than the practice of medicine and yet, one actually requiring less control in view of the high level dedication and training of its members. This is not to say we have no problems in our ranks, but rather, to say we have fewer than other professions. We do discipline ourselves and do give of ourselves to those who are our responsibility.

One year ago I spoke to you of unity, and one year later I speak again to ask your continued effort for this objective. We are in morass of difficulty which demands our collective and concerted talents which must be driven by common purpose if we are not to be dashed upon the rocks and reefs in this storm of governmental upheaval. This upheaval is directed at monetary matters and not medical need. Specific examples of this storm are clearly seen in the issue of our colleagues practicing obstetrics in Savannah. We have addressed this issue and do believe it will culminate in vindication of these physicians. Another pressing issue relates to Medicare and its appointed carrier — Aetna Insurance Company. Our aging population has been guaranteed medical coverage by a system that we were opposed to and so stated some 25 years ago. Despite our objections which spelled out the financial difficulty of this governmental proposal, Medicare is with us. It is now clear that the predictions of the AMA were correct. The State of Georgia has now become one of five in our nation in which experimental cost control programs have been instigated. As of January 1, 1989, the new carrier for Medicare and its utilization review subcontractor brought the payment for services to our patients to a profoundly reduced level, but to your credit the medical care for the patients continued. This is graphic demonstration of the professionalism of medicine. On



*Joseph P. Bailey, Jr., of Augusta, served as MAG's 1988-89 President. He left a welcome and enduring legacy for the benefit of the MAG.*

April 19, 1989, we met in Washington, DC with our congressional delegation, the Acting Director of HCFA, and the leadership of Aetna and HealthCare COMPARE. The results of this endeavor are to be seen. However, without the MAG, there would be little hope of significant intervention.

**M**edical liability problems are a continued major impediment to the practice of medicine. Your medical association has been successful in a limited fashion. Our tort reform efforts have received legislative support, and there has been a recent 18% reduction in pre-

miums by one carrier. The upcoming Georgia General Assembly will be the arena for another major effort directed at specific obstetrical reforms.

**T**his year has been a tremendous experience. The staff of the MAG has been steadfast in its support, and I cannot adequately express my thanks to them. Paul Shanor and Richard Green have been bastions of support. Each member has made his or her contribution, and I would like to mention some specific efforts of outstanding significance. [Ed. note: Several staff were named and asked to stand and be recognized.]



Your Executive Committee can be relied upon to exercise excellent judgment and expertise and do so in an untiring manner. As well, your Board of Directors. The committee structure of our organization has proven itself.

And then there is the Auxiliary. A wonderful, beautiful, talented, and hard working group that exudes enthusiasm for our purpose and goals. Jan Collins leaves a positive and great legacy to Grace Walden, the new President. To Jan I must say that you have succeeded. You are truly the Star of the Show, and you did get your act together and on the road. So much so, that the possum population of our state is now an endangered species.

I truly feel obligated to thank each member of our organization for their support but also I wish to express my special thanks to several who gave without concern for self. These individuals do not require naming, but clearly have acted in the best interest of our organization and given me as your president tremendous and unfailing support, time after time. I do thank you from the bottom of my heart.

And so, we come together this evening to conclude a year and start

another. But before doing so, I wish to acknowledge one other person — Pagie — who is truly my everything. She has supported MAG without fail in all matters and is the love of my life.

One of my goals was to be able to look back after the end of the year and say I left the Medical

Association of Georgia in better condition than when I arrived, as every President desires. It is my belief that I have achieved that goal. I do humbly express my undying appreciation to each and every one of you and pray that our God will smile upon the House of Medicine and every member of its family bestowing insight, compassion, and love. I thank you.

## Installation of New Officers

As his last official duty as President of the MAG, Dr. Bailey installed the new officers of MAG as follows:

President: Joe L. Nettles, M.D., Savannah; President-Elect: William C. Collins, M.D., Atlanta; First Vice President: Bob G. Lanier, M.D., Atlanta; Second Vice President: Roy W. Vandiver, M.D., Decatur; Speaker of the House: James A. Kaufmann, M.D., Atlanta; Vice Speaker of the House: Jack A. Raines, M.D., Columbus; Judicial Council: John D. Watson, Jr., M.D., Columbus; Judicial Council: Curtis H. Carter, M.D., Augusta; AMA Delegate: C.



*Taking the oath of office as they are sworn in as new officers of the MAG are (L to R) Jack F. Menendez, delegate to the AMA; Roy W. Vandiver, 2nd Vice President, and Joe L. Nettles, MAG's new President for 1989-90.*



*Also being sworn in are (L to R) John D. Watson, Jr., Louis H. Felder, and Charles D. Hollis, Jr.*

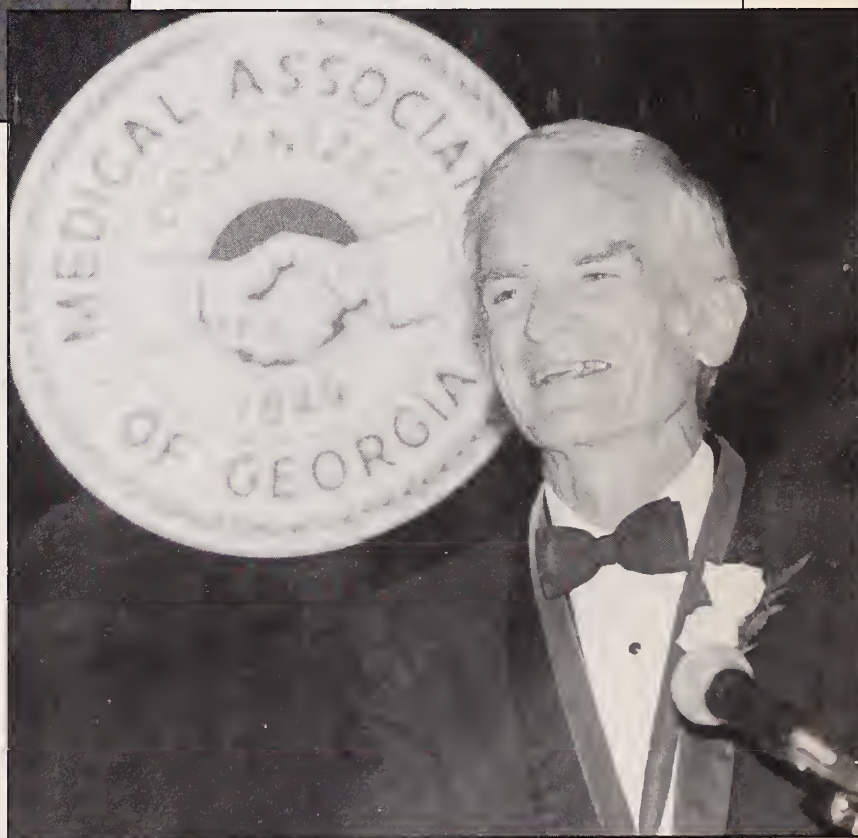


## Final General Session-Installation Ceremony

*Joseph P. Bailey, Jr., MAG's outgoing President, welcomes Joe L. Nettles as the new President and leader of the MAG.*



*(L to R) James A. Kaufmann, Joe L. Nettles, and William C. Collins making final preparations for the Installation Ceremony.*



*MAG's newly installed 1989-90 President, Joe L. Nettles, of Savannah, told those assembled that one of his major efforts in the coming year would be to improve the Medicare situation.*



Emory Bohler, M.D., Brooklet; AMA Delegate: Charles D. Hollis, Jr., M.D., Albany; AMA Delegate: Virgle W. McEver, Jr., M.D., Warner Robins; AMA Delegate: Jack F. Menendez, M.D., Macon; AMA Alternate Delegate: Richard W. Cohen, M.D., Austell; AMA Alternate Delegate: William D. Logan, Jr., M.D., Atlanta; AMA Alternate Delegate: Joseph P. Bailey, Jr., M.D., Augusta; AMA Alternate Delegate: Louis H. Felder, M.D., Atlanta; Delegate to AMA Young Physicians Section: Joy A. Maxey, M.D., Atlanta; Alternate Delegate: James F. Beattie, Jr., M.D., Fort Oglethorpe.

Ninth District Medical Society Director: John Ed Fowler, M.D., Clayton; Ninth District Medical Society Alternate Director: C. Peter Lampros, M.D., Tiger; Cobb County Medical Society Director: Dan B. Stephens, M.D., Marietta; Georgia Medical Society Director: J. Patrick Evans, M.D., Savannah; Georgia Medical Society Alternate Director: Roland S. Summers, M.D., Savannah; Gwinnett-Forsyth County Medical Society Director: Rupert Bramblett, M.D., Cumming; Gwinnett-Forsyth County Medical Society Alternate Director: Cecil L. Miller, M.D., Buford; Medical Association of Atlanta Director: William C. Collins, M.D., Atlanta; Medical Association of Atlanta Alternate Director: Bob G. Lanier, M.D., Atlanta; Muscogee County Medical Society Director: E. M. Molnar, M.D., Columbus; Muscogee County Medical Society Alternate Director: Ken L. Goldman, M.D., Columbus.

Dr. Bailey introduced Dr. Joe Nettles, of Savannah, as the new President of the MAG, and presented him with a presidential medallion. Dr. Nettles presented Dr. Bailey with the president's pin, a bound vol-

ume containing issues of the *Journal* published during his term of office, and a Past President's medallion. Dr. Nettles then addressed those assembled after which he adjourned the Installation ceremony inviting all present to attend the President's Reception.

## Incoming Presidential Address

**W**E ARE LIVING in interesting times, beset by problems in every direction. On our right lurks the threat of legal action, not just by a bad result or maloccurrence in an honest effort to help the patient but by being ensnared by a tangle of rules and regulations. The lives of all of the obstetricians in Savannah have been drastically changed. Through our efforts toward tort reform, we have received the good news this week that there finally appears to be some relief from the upward spiral of the incidence of costly, devastating suits. We must continue to support our beleaguered obstetric colleagues.

On our left is the threat of erosion from within the profession itself. In his column in this week's paper, Jack Anderson pointed out that 13% of physicians are involved in some sort of joint venture and gave statistics that show gross over-utilization in such cases. No matter how much the profession spends on public relations, it is difficult to offset that image. If we take care of our patients and practice good medicine, our image will speak for itself. Plato said, "There are two kinds of physicians. Those who treat slaves and write prescriptions, and those who treat free men and entreat, cajol, and direct them to take care of themselves."

Ahead of us we are facing a monetary crisis, with Congress mandat-

ing a 5 billion dollar cutback in Medicare expenditures. At the same time, we have an increasing aging population and increasingly complex and costly technology to offer that population. George Bernard Shaw said, "A government which robs Peter to pay Paul can always depend on the support of Paul." In this case, *Peter*, representing not only physicians but Medicare patients, will continue to remind our government that there is nothing more precious than good health. It has been said that "life is a three act play with a badly written third act!" The main thrust of my efforts this year will be toward improving that third act. We have already begun these efforts with our Senior Citizens Advocacy Program, and today's actions of the House will help us carry this program out.

Last week I retired early after a busy night on call the evening before. The telephone rang. Instead of the usual emergency room nurse, it was from Kevin, a young friend in Athens. "Dr. Nettles, I hope I didn't awaken you, but I just got my acceptance to medical school and wanted you to know." He had worked with me during summer vacations, and I had watched him concentrate all of his efforts for years toward achieving that goal. I was reminded of the time over 30 years ago when I made that decision to go into medicine. Some friends told me, "Joe, you shouldn't do that. Socialized medicine is right around the corner."

I did not tell Kevin about the clouds on the horizon. I congratulated him and told him he would make a fine doctor. Those clouds are still on the horizon, but it has been a great life, and it is still a great profession. Let's keep it that way.





*(L to R) Richard A. Cohen, Jack F. Menendez, and James A. Kaufmann relax prior to the Final General Session.*



*(L to R) Joe L. Nettles, William C. Collins, Henry Carr, and Paul Shanor.*

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chronic pain patients. The Pain Control and Rehabilitation Institute of Georgia is a well established and CARF certified comprehensive chronic pain rehabilitation facility, which is ideally located in the metropolitan Atlanta, Georgia, area. The position offers a real opportunity for professional development, with a competitive salary and excellent fringe benefits. The position is available effective July 1, 1989, with applications accepted until the position is filled. To apply, send a cover letter, CV, and three letters of reference to Steven F. Brena, M.D., Chairman of the Board, Pain Control and Rehabilitation Institute of Georgia, 350 Winn Way, Decatur, GA 30030. Inquiries about the position can be made in writing or by calling 404-297-1400.

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## MANUSCRIPT INFORMATION

**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

**NEWS NOTES** — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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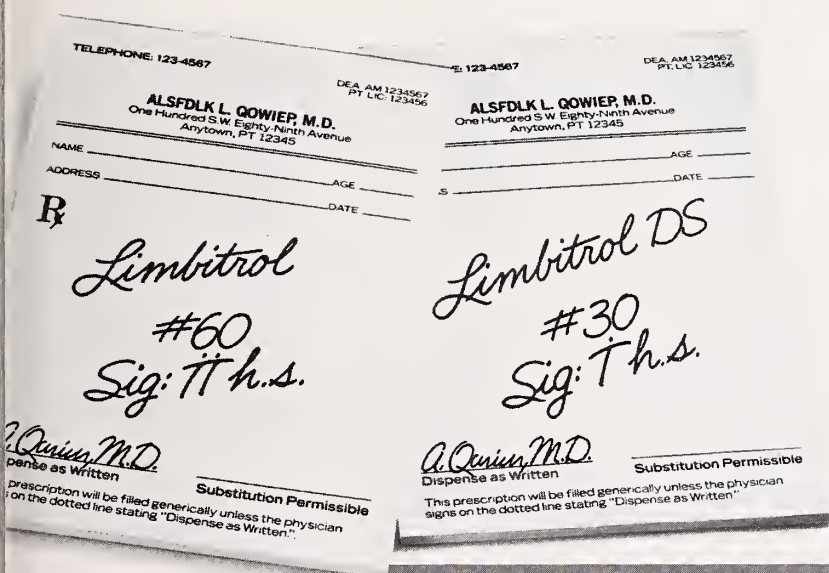
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**References:** 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

### Limbitrol®

#### Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

**Warnings:** Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

**Precautions:** Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

**Adverse Reactions:** Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. **Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. **Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. **Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. **Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. **Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. **Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. **Endocrine:** Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Drug Abuse and Dependence:** Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

**Overdosage:** Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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In the depressed and anxious patient

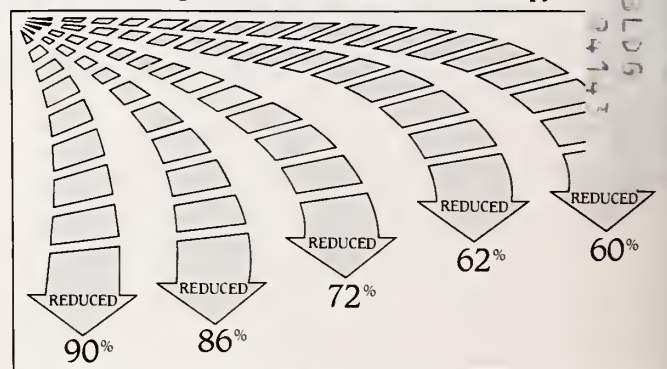
# See Improvement In The First Week

And The Weeks That Follow

- ➡ 74% of patients experienced improved sleep after the first *h.s.* dose<sup>1</sup>
- ➡ First-week reduction in somatic symptoms<sup>1</sup>

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy\*



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\*Patients often presented with more than one somatic symptom.

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AUGUST 1989

# JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

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*Pamela Joy Trow*

## A GOTHIC TALE: RURAL HOSPITALS IN GEORGIA



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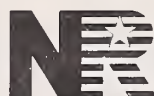
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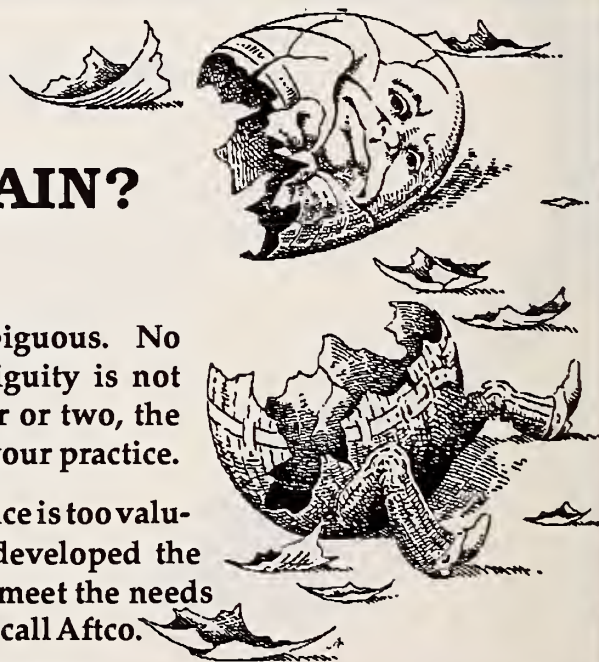
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**Brief Summary**

**Consult the package literature for complete information.**

**Indications and Usage:** Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer must heal within four weeks. Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

**Contraindication:** Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests** – False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy with nizatidine.

**Drug Interactions** – No interactions have been observed between Axid and theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility** – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose male group as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (50%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy – Teratogenic Effects – Pregnancy Category C** – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers** – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

**Pediatric Use** – Safety and effectiveness in children have not been established.

**Use in Elderly Patients** – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic** – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT, or alkaline phosphatase (greater than 500 U/L) and, in a single instance, SGPT was greater than 2,000 U/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

**Cardiovascular** – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

**CNS** – Rare cases of reversible mental confusion have been reported.

**Endocrine** – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecostasia occurred.

**Hematologic** – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H<sub>2</sub>-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental** – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity** – As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other** – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

**Signs and Symptoms** – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

**Treatment** – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the Physicians' Desk Reference (PDR). In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.



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## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

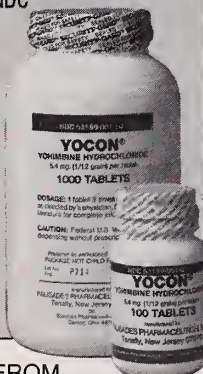
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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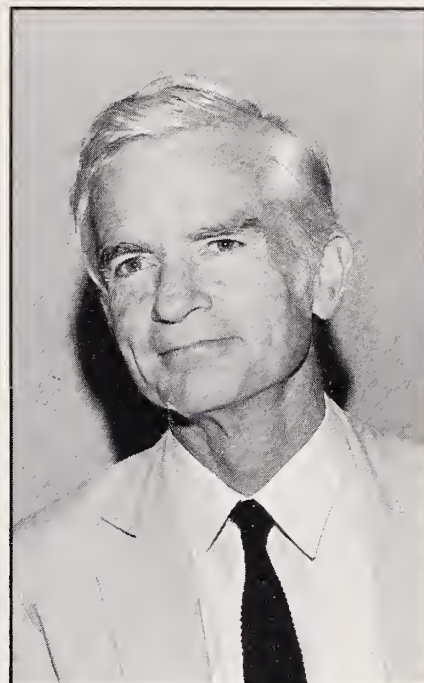
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*Joe L. Nettles, M.D.*

**I**'M WRITING THIS on my way back from Chicago after attending the annual meeting of the American Medical Association. For almost a week, we discussed the many issues relative to the practice of medicine in the United States. We heard experts testify about both present and future problems facing practicing physicians.

Today's buzzword is "Expenditure Targets," which may fast become "Expenditure Caps" — the beginning of rationing of medicine in the United States. This appears to be the way Congress is addressing the expanding health care budget. The medical profession is being asked to take care of an increasing population demanding fast-growing, expensive technology with a shrinking budget. If such legislation passes, I will have to tell a dear lady with painful, crippling arthritis that she cannot have her new hip joint this year. I will put her on a waiting list and perhaps she can get relief next year.

In Chicago, we were able to discuss the most pressing problems that affect our colleagues and patients in Georgia. The AEtna Healthcare

COMPARE Medicare Part B debacle was examined. So was the plight of Savannah obstetricians as they move into their 7th month of federal Grand Jury hearings. We are confidently hopeful that relief will be forthcoming on both issues. Countless other issues were also discussed, ranging from ethics to hospital staff problems. Strategies for dealing with these issues are being developed.

**A** few years ago, I shared the opinion of many of you that \$400 a year for AMA dues was a lot to pay for a journal that many times we don't even read. I am learning, however, after becoming more personally involved, that the American Medical Association is not some huge, distant bureaucracy, but is the sum total of the best physicians in the world all concerned about one thing — how to continue to provide our patients with the world's best medical care. I am proud to be a member of this organization.

## NEW MEMBERS

Anders, David L., Internal Medicine — Richmond (Active) BIW-547 Medical College of Georgia, Augusta 30912

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Wolff, Richard N. — Richmond —  
(Student) 3116 Ridgecrest Dr.,  
Augusta 30907

## PERSONALS

### *Bibb CMS*

**Milford B. Hatcher, M.D.**, chairman of the Department of Surgery at the Mercer University School of Medicine from April 1982 to 1986, received the honorary Doctor of Science degree at the school's commencement exercises last June. Dr. Hatcher practiced surgery in Macon for almost half a century. He was a member of the Macon Chamber of Commerce's first committee formed in 1972 for the establishment of a medical school in Macon.

### *Medical Association of Atlanta*

**Dave M. Davis, M.D., F.A.P.A.**, has been named Chairman of the American Psychiatric Association's

Consultation Service for the years 1989-1990.

The Consultation Service provides professional consultants to hospitals, departments of mental health of various states, community mental health centers, medical school departments of psychiatry, prisons, and other types of mental health facilities in the United States and around the world.

The Consultation Services responsibilities include design and planning of clinical programs, analysis of clinical and management systems, integration of services to provide continuity of care, evaluation of clinical services, conflict resolution, assistance in developing priorities among service need, advice on moving towards compliance with standards of government and private accreditation boards, planning to meet future service needs.

### *Southwest Georgia CMS*

**Homer L. Lassiter, M.D.**, a family physician in Arlington, was one of two physicians honored by the community for their 30 years of service. A reception and dinner were held in their honor, and they also served as the grand marshalls in the city May Day festival celebration.

Dr. Lassiter received his medical degree from the Medical College of Georgia and completed his internship at Macon City Hospital.

### *Thomas Area CMS*

**Jeff W. Byrd, M.D.**, was elected president of the Georgia Association of Pathologists (GAP) at their annual meeting held at the Medical College of Georgia

(MCG) on April 22. Bob Baisden, M.D., Professor of Pathology at MCG, was elected vice-president.

Dr. Byrd has served as secretary-treasurer and has been a member of the Board of Governors of the GAP for the past 4 years. As president of the state organization, he will be responsible for coordinating professional and legislative activities at the state and national level, developing educational programs, and implementing programs to encourage qualified individuals to enter the health-related laboratory field.

Dr. Byrd recently served as chief of staff and chairman of the Executive Committee at Archbold Memorial Hospital in Thomasville.

## *Upton CMS*

After practicing medicine in Barnesville for 38 years, **George T. Henry, M.D.**, has retired. His initial general practice included surgery, setting broken bones, and delivering babies.

Dr. Henry was named medical director of the Heritage Inn Nursing Home when it opened in 1976 and later also worked as medical director of a Molena nursing home.

He is now considering additional missionary work in his field. Dr. Henry has long been active in community and international Christian activities.

## DEATHS

### *Bartow CMS*

**Lewis Ross Whately, M.D.**, a family physician in Cartersville

died from a heart attack last February 17 at the age of 66.

A graduate of Emory University, he received his medical degree from Emory University School of Medicine in 1948, during which time he was elected to the Alpha Omega Alpha Honor Society.

Following an internship at Barnes Hospital in St. Louis, Missouri, he was assigned to the 406th Medical Lab in Tokyo, Japan, as an epidemiologist with the Army Medical Corps. Subsequently, he returned to Grady Memorial Hospital and completed a residency in internal medicine under Dr. Paul Beeson.

He is survived by his wife, three sons and their wives, two sisters, and several nieces and nephews.

### *Medical Association of Atlanta*

**Byron J. Hoffman, M.D.**, an internist for 50 years, died in June of complications from cancer. He was 78.

Dr. Hoffman began his practice of medicine in Atlanta in 1936; he retired earlier this year. During World War II, he rose to the rank of major as an Army doctor in North Africa, Italy, and France.

Born in Gaston County, N.C., Dr. Hoffman graduated from Duke University in 1932 and received his medical degree from Emory University School of Medicine 4 years later. He completed his residency at Grady Memorial Hospital in Atlanta.

Dr. Hoffman was on the clinical faculty at Emory's medical school for many years and held membership in many professional associations. He was also a past Chairman of the Board of Trustees of Fernbank, Inc.



## Of Clay Courts and Rivers

**T**he country habit has me by  
the heart.  
*I never hear the sheep-bells in the  
fold,  
Nor see the ungainly heron rise  
and flap  
Over the marsh, nor hear the  
asprous corn  
Clash, as the reapers set the  
sheaves in shocks  
(That like a tented army dream  
away  
The night beneath the moon in  
silvered fields),  
Nor watch the stubborn team of  
horse and man  
Graven upon the skyline, nor  
regain  
The sign-posts on the road  
towards my home  
Bearing familiar names —  
without a strong  
Leaping of recognition; only here  
Lies peace. . .*

VITA SACKVILLE-WEST  
"The Land"

**T**HEY WERE TELEVISIONING the  
French Open that Saturday  
afternoon while I sat at lunch.  
The announcer went on at great  
length to explain to us viewers  
that this gathering represented the  
only major tennis tournament  
played on "real" clay. They were  
at Roland Garros Stadium in  
Paris, with thousands watching as  
the princes of the world of  
professional tennis did their thing.  
And suddenly, there it was in  
living color right before my eyes.  
Real, sure enough, red clay! The  
Real Thing. I had grown up on

red clay tennis courts in a little  
country town in Alabama and  
now found that same red clay  
every time I scratched the topsoil  
in Georgia. I had grown up with  
red clay courts, chicken wire nets,  
and slick worn balls. But this was  
Paris, City of Light. The place to  
be or to have been in the 20s  
were one a Gertrude Stein, a  
Hemingway, a Fitzgerald, or  
anyone who thought themselves a  
writer or an artist. Paris or not, I  
thought to myself, red clay is red  
clay, and this looks like Georgia  
red clay to me.

**I** thought about that red clay  
when I sat down to put  
together the "Editor's Corner" this  
month, for we deal in this issue  
with the rural hospital, with its  
past and its unpredictable future.  
The relationship of the two  
seemed natural, for hidden deep  
in the subconscious mind of  
those of us in the South there is  
something which equates red clay  
with rural. Perhaps the  
explanation lies in our proclivity  
to cover our city land with  
concrete or asphalt, thus hiding  
the clay. After all, it was  
Buckminster Fuller who told us  
that our national flower is the  
concrete cloverleaf.

I have an unabashed feeling  
that I understand a broad range of  
the environment in which  
medicine is practiced and in  
which hospitals exist. That  
understanding comes from a

hospital life that started with the  
washing of surgical instruments in  
a small, rural hospital at 15 years  
of age. In that hospital, I learned  
firsthand the meaning of general  
practitioner in its most general  
connotation. Learned also the  
requirements made of a 25-bed  
hospital and the limitations with  
which the professional staff  
confronts such an institution. But  
the experience broadened with a  
medical education in a major city.  
Expanded further with residency  
training in a pressurized  
academic center. And then took  
on meaning and understanding as  
a practice developed in a major  
metropolitan area.

Perhaps it has been in the  
passage through the years in  
practice that one saw best the  
void between the rural and the  
urban practitioner and hospital.  
We have a river which flows  
between our rural area, for so it  
was when I first came to it, and  
the urban area further south. In  
those early days, most of those  
with self-assured knowledge and  
insight, and dollars to support  
such, passed through our town,  
crossed the river, and went to the  
city doctor. There seemed to be a  
magic balm in that river the mere  
crossing of which lent to one a  
therapeutic prowess and efficacy  
not available to lesser men. But  
we struggled on as capable young  
men and women physicians  
joined our little group of country  
doctors. The patients don't cross

the river so much these days. Somehow, we have become urbanized. An unanticipated and unwarranted crown of authenticity has been placed upon our heads.

Although crowned we be, yet we are the same physicians we once were. Wiser perhaps because of the years. More knowledgeable, hopefully, because of study. But has urbanization made us better doctors? Has the association with more of our peers, and they of diverse disciplines, broadened our own insight and capability? Has such association dulled our thirst for knowledge found only in the literature of medicine? Do we think less for ourselves because others do part of our thinking for us? Perhaps the ultimate question before governmental and medical policy groups alike is whether or not the delivery of medical care of a quality as good as it should be can be accomplished in the rural setting. Has the cost of such care, with its associated technology, reached such levels that it can only be provided in a hospital of a certain size located in a city of a certain population? Can physician performance as judged by peer review be relied upon in an environment with few peers? Finally, is the rural hospital a modern day financial dinosaur, an anachronism of our medical past?

**S**urely as the sun shall rise on the morrow shall our medical world of next year possess a different look. And yet, so long as physicians yearn for knowledge, strive for technical improvement, treat the sick with compassion, and harbor no fear of scrutiny by their peers, so long shall the rural physician prosper. So long as hospitals provide facilities of equal acceptance, search diligently for honest and

efficient cost control, provide necessary technical equipment, and see the physician as something more than another deductible piece of capital equipment, so long will the rural hospital exist. We have now come to a time in the challenge of caring for the sick when the abrogation of any of these responsibilities will lead to even further centralization of health care providers and the facilities available to them. The day of the silent physician, unregulated, unreviewed, and unaccountable is now, as it should be, unacceptable. Likewise the day of the rural hospital existing solely for the convenience of a populace but unable because of fiscal and professional capability to measure to a standard must be relegated to the history of the provision of medical care. The rural physician must today and in the future be the equal of the rural physician of the past — and something more — not something less. The rural hospital of the future, should it continue to exist, must stand as a microcosm of its peer institution in the more populous areas.

**I** looked back at Roland Garros Stadium and its red clay court. I thought of how many such courts there used to be and now only on television and that in Paris. I thought of the river in my community one barely sees now while racing across the modern bridge with its high protective wall blotting out the once calming view. No longer that river a solid barrier for the demarcation of the rural and urban physicians and their hospital, for that barrier lies further out beyond the perimeter. The demarcation must now fade into historic significance. Surely differences between rural and urban medicine will continue to

exist, but such variances must become increasingly ones of scale and not of quality.

Hanging upon the wall in my reception room is a sepia tone photograph of four Underwood brothers, all country doctors. They sit in coat and tie astride four fine and well groomed horses, saddle bags in place, prepared to leave to make their rounds through the countryside about their tiny hamlets. The year is 1910. Those hamlets have no physician now. They are all congregated in the nearby town. The family physician who sutured my lacerated foot on his living room couch is now a Board surgeon in the city. The hospital where I learned of surgical instruments is now a nursing home. The clay tennis court lies quietly beneath the new municipal building. The river flows quietly and peacefully on its way to the Gulf.

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## *Physicians Supply in Georgia*

*M. Julian Duttera, M.D.*

**E**LSEWHERE IN THIS JOURNAL, an important and informative article by Dever et al. describes the 1986 Georgia Physicians Survey conducted by the Composite State Board of Medical Examiners. The data from this survey are of great importance to all physicians in Georgia. The impact of these data will vary depending on the physicians' location, but the information will be particularly useful in understanding where physicians are currently practicing as well as aid in planning for the future. For the first time we have data which accurately define who is practicing in the state and where they are practicing.

The most striking finding in the survey is that there is still a substantial deficit of physicians in Georgia. We have 148 physicians per 100,000 population as compared to the current national average of 192 physicians per 100,000 or to the Gemanac ideal of 200 physicians per 100,000 as a goal set for 1990. Even the metropolitan area of Atlanta has fewer physicians than the national average, with 185 physicians per 100,000. When one considers the non-metropolitan areas of Georgia, the number drops to 84 physicians per 100,000, a substantial and significant deficit.

The article by Dever et al. also contains projections of the

physician data to the year 2000, with projected increases in physicians and population. It is estimated that in the year 2000, using the assumptions outlined in the Dever paper, that the physician per 100,000 patient population will be 160, suggesting the persistence of a severe deficit. Projecting this figure another way, based on AMA data and the rate of increase of physicians over the last 25 years, one would conclude that the deficit would not be as severe by the year 2000 but would approach the 200 physicians per 100,000 people. There is certainly no reason to project from the AMA data, however, that the rural population will get a larger proportion of these physicians.

**T**he deficit of physicians in rural areas remains a major problem both for the physicians who practice in those areas and for the State of Georgia. Physicians in rural areas can expect continued high demand for their services and long hours. Scarce medical care may make these areas of Georgia less attractive for industrial development and thereby contribute to the problem of "two Georgias."

Efforts are underway on several fronts which should yield favorable results. The Medical Education Board and the Medical

**‘The most striking finding in the survey is that there is still a substantial deficit of physicians in Georgia.’**

Association of Georgia continue to sponsor the Medical Fair in conjunction with a number of other organizations. This Fair provides a well developed placement format for communities of less than 15,000 and has allowed these communities access to residents unlike anything previously available to these communities. Unfortunately, very small communities, and particularly those without hospitals, find themselves at a disadvantage in this setting because of the lack of organizational efforts and recruiting expertise. The Medical Education Board has put a triple indemnity clause into its scholarship program which will make it much more expensive for scholarship recipients to buy out of their scholarships. Failure to keep a scholarship commitment

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Dr. Duttera practices oncology and is Medical Director, Enoch Callaway Cancer Clinic, 111 Medical Dr., LaGrange, GA 30240. Send reprint requests to him.

will require the payment of more than \$75,000 from a physician who does not comply with the terms of the contract. In addition, specialization of the scholarship recipients has been strictly limited to the primary care specialties.

The Joint Board of Family Practice now has two fulltime recruitment staff members whose principal function is to help place physicians from family practice training programs within the State of Georgia. They also serve as a clearinghouse for other specialties who are interested in practice within the state, including physicians trained in other parts of the country.

Mercer University School of Medicine continues to emphasize practice in rural areas, although some doubt is cast on this mission by the fact that not a single senior in the 1988 class continued training in a family practice training program, the specialty most likely to serve in a small community.

**T**he economic implications of high demand for services and low physician numbers has a positive side for physicians. *Medical Economics* reported that the 1985 net income for physicians in Georgia was the highest of any of the 13 major states which they surveyed, \$130,830. This finding occurred despite the fact that first visit and re-visit charges for Georgia were below the U.S. median visits in 1986. It was postulated that income was high because Georgia physicians saw a heavier caseload than physicians in other parts of the country, with an average of 113 patients a week reflecting the smaller number of doctors in the state.

Based on projections in the survey or on the more

conservative projections using AMA data, it would appear that demand will remain high for services, and, therefore, physician income should remain good (as long as fee-for-service payment is the predominant method of reimbursement). On the other hand, access to medical care for patients, particularly in rural areas will be more difficult, and this is certainly a negative for the population of the state.

## **‘The economic implications of high demand for services and low physician numbers has a positive side for physicians.’**

**I**t is also interesting to speculate about the implications of these numbers for a penetration of the HMOs within the state. It is clear that states with major penetration of HMOs, such as California and Minnesota, are also those with major excesses of physicians. According to 1986 AMA figures, California ranks seventh in the country, with 267 non-federal physicians per 100,000, and Minnesota ranks fourteenth, with 226 non-federal physicians per 100,000. By comparison, Georgia ranks thirty-sixth. It is interesting to speculate whether the lack of “excess” medical manpower will make penetration of HMOs more difficult into the state market.

It is hoped that these data will prepare us to better deal with the realities of medical practice rather than using our own pre-conceived biases, which may have been misleading in the past because of the absence of reliable data.



## *China and the Democratic Students*

Charles B. Gillespie, M.D.

**I** RECENTLY HAD the opportunity to experience some of the most extraordinary demonstrations of courage and determination in my life. On May 18, I departed on a trip to China, never realizing that the then active student demonstrations would continue to the point of confrontation as we know it now. As soon as I arrived in Shanghai, I realized that the cry for freedom went far beyond the protests of the students in Tiananmen Square. I immediately found myself in the middle of thousands of chanting, marching Chinese students and citizens who were asking their government to respond to their demands for democratic reforms. Perhaps the most moving moment during this first encounter was when the demonstrators appeared with a 15-foot symbol among their many signs and banners — none of which I understood. That symbol was the exception, for it was a replica of our own (at that moment “their”) Statue of Liberty. Their faces and the “V” for victory signs they presented to all who watched showed true hope in improving their futures. There were the young, old, civilians, and military in those crowds. And at that time, not one incidence of violence was to be seen anywhere. It is hard to describe my feelings after noting such uniformity of purpose. I shall never forget what I saw and felt

that night in that “freedom crowd.”

And then there was Beijing. At first, I retained the same feelings from Shanghai. The students occupying Tiananmen Square were equally pleasant and peaceful. They asked for the support of every visitor they saw. There were requests for our autographs and written statements that we supported the movement towards democracy. I was even asked to call President Bush and tell him about the students and what they are trying to achieve. Once again, no violence was seen. Admittedly, hygiene was a problem in the Square area, as no facilities were close by, but even that was being managed well by the volunteers and public sanitary workers. I, along with everyone else I spoke to, was convinced that their movement was patriotic and their political ideals legitimate. In simplistic terms, those in the Square were expressing their disillusionment after decades of unfulfilled promises — they were demanding nothing less than a say in how they are governed. Similar feelings were being actively expressed in at least 30 other Chinese cities and around the world. While Mao Tse-tung’s heirs fumed and plotted within their compounds, the world watched in amazement as the future of one-fifth of humanity was played out.

Despite such early calls from

***“It is hard to describe my feelings after noting such uniformity of purpose. I shall never forget what I saw and felt that night in that “freedom crowd.”*”**

one army commander who said to the demonstrators: “We can help each other and keep peace in the Square — be calm,” the world now knows what happened when the politicians could not solve their internal disputes. The armed soldiers that followed the rigid orders of their communist dictators had been brought in from outside the capital, most unaware of the nature of the massive prodemocracy protests. They had been told they were to go on manoeuvres and were only to control rioting mobs of criminals. In contrast with the first military units, these new soldiers were armed with tear gas, high-pressure hoses, and AK-47 rifles. And then these new soldiers were put to work. . . .

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Dr. Gillespie is an orthopedic surgeon. His address is 2315 Winchester Rd., Albany, GA 31707.

**W**hy was all this occurring? In speaking with many local citizens while in China, I concluded that their demands for more freedom and democracy was bound to happen. As in many other countries, the school campuses have provided the best incubators for change and new ideas. In China, as elsewhere, workers, farmers, and many others have looked to the students to spearhead the new leadership movements, as they are usually the "cream of the crop" from an intellectual standpoint. They have decided that the world movement towards democracy now fits their needs as well. At this time, they have kept their demands simple — freedom from corruption, freedom of speech, freedom of the press and the right to elect their leaders in open contests. Only about 10 percent of the people are members of the Communist Party. The other 90 percent just do not believe it is appropriate for the majority to be left out of the political process.

At first, I did not believe China's officialdom would ignore the popular clamor in the Square and elsewhere, even though it was obvious that it would not be easy for them to share power with the citizenry after 40 years of absolute rule. True, the "going would be rough" for both sides, as their resilience and pragmatism would be put to the test from minute to minute. In the end, however, Mao's old statement that governments will survive only through the end of a gun once again held true.

It is very difficult for me to accept the fact that many of the students with whom I spoke are now dead in the name of democracy, not just for themselves but perhaps for all of

us. The courage of those individuals, and particularly the single student who recently walked in front of the tank column, should make us all realize that these people are working for all of us. What I now realize more than ever is that

none of us should ever take our democracy for granted nor fail to support all persons around the world who show us their signs of victory and freedom. We should all help them build their "Ladies of Liberty" in every instance.



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*From Bynum's scrap-book:*

GELETT BURGESS, 1856-1951, Massachusetts-born author and poet. It was about a century ago, while editing *"The Lark"* (1895-7) that he wrote his famous quatrain, "The Purple Cow":

*"I never saw a purple cow,  
I never hope to see one;  
But I can tell you anyhow,  
I'd rather see than be one!"*

Most of the things he wrote were designed for the especial delight of children. But he often took an opportunity to nudge grown-ups on matters of behavior.

**"The Educated Heart"**

*"Everything can be done beautifully by the Educated Heart, from the lacing of a shoestring so it won't come loose, to passing the salt before it is asked for.*

*When you do a favor, do it to a full length of the rope. Don't send a telegram in just ten carefully selected words; add a few extra phrases that make the reader perceive that you care more for him than the expense.*

*You call once or twice at the hospital, do you ever call again? Not unless you have an Educated Heart. But one there was who wrote letters every day. One who rescued the clock that always had something in front of it so you couldn't see the time, who was careful not to hit the bed, who talked to you instead of the Distinguished Caller who happened to be present.*

*Nothing is so rare as The Educated Heart — the Educated Heart does kindness with STYLE! And what a becoming style it is. Persons with an Educated Heart constitute man's true aristocracy, as if by instinct they are able to put themselves in anothers' place. They do a kindness in the kindest way!"*

RICHARD BYNUM WEEKS, M.D.  
Retired Surgeon,  
St. Simons Island

*We invite contributions to this Department. Please send them c/o the Journal, 938 Peachtree St., Atlanta 30309.*

## AUGUST 1989

24-27 — *Sea Island: Tri-State Otolaryngology Association.* Category 1 credit. Contact Robert A. Gadlage, MD, 2121 Fountain Dr., Ste. C, Snellville 30278.

## SEPTEMBER 1989

9 — *Atlanta: Pediatric Dermatology for the Primary Care Physician.* Category 1 credit. Scottish Rite Children's Hospital, CME Office, 1001 Johnson Ferry Rd., Atlanta 30363. PH: 404/256-5252.

11-12 — *Atlanta: Interventional Radiology for Technicians & Nurses.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

11-15 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-17 — *Augusta: Clinical Psychiatry.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

18-19 — *Atlanta: Third Annual Menopause Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

21-23 — *Hilton Head, SC: Frontiers in Nutrition.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

22-23 — *Atlanta: Lung Cancer Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

22-23 — *Atlanta: Medical Retina Workshop.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23 — *Atlanta: Second Annual Cleft Lip & Palate Symposium: Oral-Musculo-Skeletal Considerations in Cleft Care.* Category 1 credit. Scottish Rite Children's Hospital, CME Office, 1001 Johnson Ferry Road, Atlanta 30363. PH: 404/256-5252.

25-26 — *Atlanta: Quantitative Thallium Myocardial Tomography.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-28 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXII.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-26 — *Atlanta: Congress of Neurological Surgeons.* Contact CNS, 1840 North Soto St., Room 100B, Los Angeles, CA 90033. PH: 213/224-5435.

25-29 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## OCTOBER 1989

4-6 — *Atlanta: Biliary Lithotripsy and Adjunct Procedures.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: GA Chapter, American Academy of Pediatrics.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., NE, Atlanta 30346. PH: 404/237-3922.

9-11 — *Savannah: Neonatology — The Sick Newborn.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-13 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-14 — *Atlanta: Renal Disease Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-15 — *Sea Island: Georgia Orthopaedic Society.* Category 1 credit. Contact Jeff Nugent, M.D., 105 Collier Rd., Ste. 5000, Atlanta 30309. PH: 404/355-0743.

13-14 — *St. Simon's Island: Nephrology Update 1989.* Sponsored by The National Kidney Foundation of Georgia. Category 1 credit. Contact NKGK, 1639 Tullie Circle, Suite 108, Atlanta 30329. PH: 404/248-1315 or 800/633-2339.

15-20 — *Atlanta: American College of Surgeons.* Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH: 312/664-4050.

15-20 — *Atlanta: American Society of Colon & Rectal Surgeons.* Contact ASCRS, 800 E. Northeast Hwy. #1080, Palatine, IL 60067. PH: 312/359-9184.



### Hospitals Honor Four Georgia Legislators

**F**our Georgia legislators took top honors this month for their work in promoting health care in the state.

The four were recipients of the Georgia Hospital Association's Legislator Appreciation Awards, which are given each year to state lawmakers who have made outstanding achievements in the promotion of health care delivery.

They are Sen. Terrell Starr of Clayton County, Rep. Jim Beck of Valdosta, Rep. Terry Coleman of Eastman, and Rep. Buddy Childers of Rome.

Sen. Starr was honored for his work in helping fund the state Medicaid program and also for his support of a hospital rate adjustment in this year's Medicaid budget.

Rep. Jim Beck is chairman of the Medicaid subcommittee on appropriations. During this year's General Assembly, that committee recommended several improvements that will benefit the hospital industry, including rate adjustments, swing beds for small rural hospitals, outlier adjustments, and expanded eligibility for the medically needy. Those recommendations made the issues matters of serious consideration in the legislature.

Rep. Terry Coleman also supported a hospital rate adjustment. Further, he is the author of legislation that will help young physicians locate in medically underserved areas of the state by financing their

educational debt.

Rep. Childers has for many years given consideration to the issues affecting hospitals and this year authored the hospital association's proposal that would have required all counties to contribute to the cost of indigent health care. Although the bill did not pass, the heated discussion that followed prevented the problem's being swept under the rug.

Rep. Childers further authored a resolution creating the Access to Health Care Study Commission, which will study the problem of the shortage of health care professionals and make recommendations for state action.

### Government Eyes Billing For Itinerant Surgery

**P**hysicians who perform itinerant surgery have come under the watchful eye of the Office of the Inspector General (OIG).

As a result of its recent findings that more than half of itinerant surgeons bill Medicare global fees even though they do not provide postoperative care, the OIG has recommended that the Health Care Financing Administration instruct the Medicare carriers to recover overpayments from those surgeons who continue to do so.

The government study was conducted in 1985 and 1986 and investigated itinerant surgery performed in 72 rural hospitals. The OIG has recommended that

rural physicians and their hospital administrators set up procedures that will ensure patients receive adequate pre- and postoperative care and will also allow for second surgical opinions for the patients. In addition, the OIG want the peer review organizations to review the procedures itinerant surgeons perform.

### Medicare Considers Expense Limits for Physicians

**T**he House Ways and Means Committee's health panel has approved a package of money-saving measures that would put Medicare expenditure targets on physicians beginning in fiscal year 1990. Under the proposal, the government could set separate targets for hospital-based physicians, for example, or targets based on state or regional expenses. If physicians in one group overspent their target, that group would have less money to spend the following year.

In addition, the committee's package would limit doctors' ability to "balance bill" their Medicare patients.

The measure is part of the overall effort of budget reconciliation and will soon go to the full Ways and Means Committee for a vote. The outcome may be in its favor, as the proposal is gaining allies in Congress as well as in the administration.

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# A Gothic Tale: Rural Hospitals in Georgia

W. Douglas Skelton, M.D., Denise D. Kornegay, M.S.W., C. Annette Maxey, M.S.W.

## An Overview Nationally

**A**CROSS THE NATION, many rural hospitals have closed or are on the brink of closure. The effect of the loss of rural hospitals on the economies and on the health status of the rural communities they serve will negatively impact the economic future of many rural areas, as well as further reduce the health status of the poor and the elderly who are represented in higher numbers in most rural areas.

Hospitals in large numbers were financed by the Federal Hill-Burton program of the 1940s, which attempted to assure every American of accessible medical care within their own community.<sup>1</sup> The small, rural hospitals were built to meet the needs of an agrarian society. As the economies of rural America changed, many people left the farms for the opportunities of America's urban areas. This demographic change is a major contributor to the current difficulties of the rural hospital, i.e., less people to serve and more of those the poor, the elderly, and in Georgia, minorities.<sup>2</sup> Also, the Hill-Burton hospitals are now

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**For all rural hospitals, nearly two-thirds of revenues are generated through Medicare and Medicaid; whereas less than one-half of urban hospital revenues are dependent upon these reimbursement systems.**

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old and in need of expensive replacement or renovation.

Until the 1970s, the hospital was often the largest and most economically successful employer in a rural community. When medical care

costs became a concern in the 1970s, the government began a series of cost reduction efforts that moved the federal government into a cost-based reimbursement of care rather than a retroactive/charge based reimbursement. This resulted in hospitals being paid a flat fee for a specified service, regardless of acuity of illness or length of stay.

Federal reimbursement has not kept pace with the cost of care and at the same time, private payers have been less and less willing to pay bills inflated to cover the federal reimbursement differentials or to care for indigent patients. Payment problems were exacerbated by a greater need for services by the poor, including the minority poor, who with little or no ability to pay, often delay care until their illnesses are more severe. Rural hospitals struggling to meet individual patient needs for more care were faced with declining numbers of available physicians and other medical care providers.<sup>2</sup>

The decline of inpatient hospital utilization and the shift to outpa-

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Dr. Skelton is Dean and Provost of Mercer University School of Medicine. He is also Chairman of the State Health Policy Council and Chairman of the State AIDS Task Force. Ms. Kornegay is the Associate Director, Office of Health Policy, Mercer University School of Medicine. Ms. Maxey is Executive Director, State Health Planning Agency.

Send reprint requests to Ms. Kornegay at Office of Health Policy, Mercer University School of Medicine, Macon, GA 31207.

tient care has had a major impact on smaller hospitals. Since 1980, small and rural hospitals nationally have experienced a decline of 42.3% in admission; 11.2% in average lengths of stay; 23% in average daily census, and 34.2% in occupancy rates.<sup>1</sup> An absolute decline in the total number of hospitals began after 1977. Nearly all of the hospitals that closed had fewer than 200 beds; 65% had fewer than 100 beds.<sup>1</sup>

### **The Situation in Georgia**

How vulnerable are Georgia's rural hospitals to these trends? In the spring of 1987, Governor Joe Frank Harris expressed his concern about Georgia's rural hospitals by asking the State Health Policy Council (SHPC) and the State Health Planning Agency (SHPA) to convene a Task Force to assess the problems and make recommendations as appropriate to the needs of rural Georgians. The Task Force was comprised of representatives from the Association of County Commissioners, the Georgia Municipal Association, Mercer University School of Medicine, Morehouse School of Medicine, the Medical College of Georgia, the Georgia Academy of Family Physicians, the Georgia Nurses Association, the Georgia Association of County Boards of Health, the Georgia Business Council, the Georgia Medical Association, the State Medical Education Board, the Department of Medical Assistance, the Office of Regulatory Services/ Department of Human Resources, the Georgia Osteopathic Medicine Association, the Georgia Hospital Association, the Georgia Rural Health Association, the Cooperative Extension Service, and the State Health Policy Council. Dr. W. Douglas Skelton, Provost and Dean of the Mercer University School of Medicine, served as chairperson. The Task Force report was sent to the Governor in June of 1988, after having been reviewed and endorsed by the State Health Policy Council in April and May of that same year. Summarized below are the findings and recommendations included in the full report to the Governor.

### **Report of the Task Force**

The Task Force began their work by reviewing the current status and recent past of Georgia's rural facilities. Regarding the availability of practitioners in the rural areas, they found that as a county in Georgia becomes more rural, the number of health professionals per 100,000 population decreases.<sup>3</sup> Within non-metropolitan statistical areas, the

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**To compound the lack of health care manpower in the rural areas, the Task Force found that, like those nationally, the hospitals in the rural areas were constructed largely during the Hill-Burton era. . . .**

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central Georgia region had the lowest rate of professionals per 100,000 population. The southwest also had a high degree of need for additional health professions. To compound the lack of health care manpower in the rural areas, the Task Force found that, like those nationally, the facilities in the rural areas were constructed largely during the Hill-Burton era, and most had not undergone serious renovations or replacements since their opening. A capital source for renovations and replacements was a need identified in the Task Force's work.<sup>4</sup>

In Georgia, the declines in rural hospital utilization are also apparent. Table 1 depicts the historic aggregate occupancy rates for rural and urban hospitals in Georgia for the period of 1982-1985. As shown

by this table, the average daily census has also declined.

As indicated in Table 1, primary rural hospitals (located in a non-MSA county with population density per square mile less than 100 persons), experienced a substantial decrease in annual occupancy and in average daily census in recent years. Since 1976, approximately 12 rural hospitals have closed in Georgia. In 1987, the year of the Task Force's activity, 61% of the state's general acute care hospitals were in rural areas.

Demographic changes were evident in Georgia. A 1987 Rural Economic Development Study published by the Department of Community Affairs (DCA) found a below average growth rate for rural Georgia. Approximately 40% of the state's total population resides in a rural area, however, 48% of the aged 65 and older live in the rural areas. The median age of rural Georgians has accelerated at a higher rate than urban Georgia. Median age statistics do not fully represent the most troubling rural population trend, i.e., a significantly higher percentage of rural Georgians are either over the age of 65 or under age 18.<sup>5</sup> These age groups make the greatest demand on the health care system.

Having ascertained that rural hospitals in Georgia were in fact, experiencing financial as well as demographic pressures, the Task Force addressed specific issues. Of prime importance was the Task Force statement that "... the presence of viable rural hospitals was necessary to insure access and availability of health care services to all Georgians."<sup>4</sup>

Nine public meetings and 10 rural hospital case studies identified concerns which were grouped under the headings: Community Health Care Needs; Indigent Care; Regulatory and Reimbursement Issues; Access to Capital; and Health Care Professional Recruitment and Retention. Several findings and recommendations from the sections on Community Health Care Needs, Indigent Care, and Reimbursement Issues are discussed in this article.



### Community Health Care Needs

The Task Force developed a list of basic medical care services that should be reasonably available to every community. This list includes: primary and ambulatory care including routine health maintenance, immunization, prenatal and postnatal care; programs for disease prevention and health promotion; emergency medical services including stabilization and available ground ambulance transport services; basic diagnostic capabilities such as: x-rays (extremities and chest), fluoroscopy, and laboratory (chemistries, urine, blood, bacteriologies, and other services at the same level of complexities); selected acute short term hospital services such as services for uncomplicated childbirth within 30 minutes travel time, inpatient and outpatient surgeries, respiratory and physical therapies, and other non-surgical medical treatments; primary and emergency dental care accessible within 30 minutes travel time; mental health services including outpatient and crisis intervention; in-home services including home health services; long-term care facilities; end-stage renal disease chronic dialysis treatments within 30 minutes travel time; and transportation available to insure geographic accessibility to all services.<sup>4</sup>

The Task Force anticipated that rural communities would use the list as a guide to help in the identification of community health needs. Rural hospitals are needed to provide some of these services and may also provide other services such as adult day and respite care, well and sick child care, employee assistance programs for local industries, transport services, health promotion/disease prevention programs, and other programs appropriate for special populations that may reside in their community. These programs meet other community needs and improve the hospital's finances.

*Recommendation:* The Task Force recommended that an Office of Rural Health be estab-

lished to perform such services as technical assistance to rural communities and to rural hospitals to facilitate a local planning process that would identify the needs and capabilities of the community.

### Indigent Care

Currently in Georgia, there does not exist a consensus about a strategy for addressing uncompensated indigent/charity care. In Georgia, rural and urban acute care general hospitals aggregately provide equivalent levels of uncompensated care. According to the indigent care survey reports for the last half of 1986, rural and urban hospitals provided an aggregate 2.7% of uncompensated care of their total adjusted gross revenues.<sup>6</sup> However, this figure did vary for rural and urban bed-size categories. Not surprisingly, it is the small (less than 50 beds) rural hospitals and the large (200+ beds) urban hospitals that deliver the highest percentages of uncompensated care. Uncompensated care is a problem for all providers; it has become a major problem for the small rural and large urban facilities, especially those that are referred to in Georgia as *public hospitals*.

*Recommendations:* The Task Force urged the Governor to oppose the adoption or creation of any policies that might encourage a two-tier system of delivery of basic health care in the state

## A Task Force was assembled at the request of Governor Joe Frank Harris to assess the problems and make recommendations as appropriate to the needs of rural Georgians.

of Georgia. Further, they urged the development of a plan to assure access to an entire continuum of basic health care to all Georgians. An increase in services provided by county health departments and primary care centers, as well as continued expansion of Medicaid, were anticipated components of such a plan. The Task Force joined the Association of County Commissioners in their call for a Governor's Blue Ribbon Task Force to study the Indigent Care problem in Georgia.

### Regulatory and Reimbursement Issues

Regulations that are established to affect an entire industry create different problems for each segment of that industry. This has been

**TABLE 1 — Historic Hospital Utilization in Georgia's Rural and Urban Facilities**

**Key:** ADC = Average Aggregate Daily Census

AAOR = Average Aggregate Occupancy Rate

	Urban	Secondary Rural	Primary
ADC 1982	190.7	126.7	27.0
ADC 1983	188.2	126.9	26.1
ADC 1984	179.5	118.0	24.6
ADC 1985	168.5	110.8	21.2
AAOR 1982	62.2%	65.5%	48.1%
AAOR 1983	62.6	65.5	48.7
AAOR 1984	57.9	60.3	42.8
AAOR 1985	59.3	57.8	39.3

Source: Joint Hospital Questionnaires, 1982-1985. State Health Planning Agency.

the experience of the rural hospital under the Medicare and Medicaid reimbursement systems. Medicare payments for services delivered in rural settings have a major impact on the finances of the rural hospitals. Rural areas generally have a disproportionately higher percentage of elderly than urban areas. Elderly persons, as a group, have been shown to require more hospital care than any other age cohort. With the advent of DRGs and the rural/urban differential upon which payment is based, many rural hospitals have experienced revenue losses. In Georgia, rural hospitals rely heavily on the revenues generated by their Medicare and Medicaid patients. In the aggregate, small rural hospitals derive 66.3% of their total adjusted gross revenues from Medicare and Medicaid.<sup>7</sup> For the same size urban facility, the percentage is 52%.<sup>7</sup> For all rural hospitals, nearly two-thirds of revenues are generated through Medicare and Medicaid, whereas less than one-half of urban hospital revenues are dependent upon these reimbursement systems. Clearly, rural hospitals have less full-pay patients to compensate for their Medicaid/Medicare losses.

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## **The decline of inpatient hospital utilization and the shift to outpatient care has had a major impact on smaller hospitals.**

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*Recommendations:* The Task Force urged the Department of Medical Assistance (DMA) to explore Medicaid reimbursement for swing beds, i.e., nursing home beds in hospitals, as well as to increase the levels of reimbursement to physicians to encourage broader participation in the Medicaid program. Further recommendations to DMA centered around changes in the outlier payment mechanism, as well as a request for additional educational programs for hospital administrators concerning Medicaid policies and procedures. Georgia's Congressional delegation was urged to address such issues as Medicare reimburse-

ments for transferred patients, and the "upperlimit" reimbursement policy governing Medicaid's reimbursement levels.

**I**n conclusion, the Task Force found that rural hospitals in this state are indeed facing a troubled future. The Task Force agreed that healthy and viable rural hospitals were necessary to the medical care delivery system in Georgia to assure accessible and available basic medical care services to all Georgians.

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# Looking Back To See the Present

Leonard T. Maholick, M.D.

*In this short life  
That lasts only an hour  
How much — how little — is  
Within our power*

EMILY DICKINSON

**A**NYONE WHO HAS LIVED long enough to reach the age of 65 is a long lifer, and I am one of them. I am glad to be viably alive at 67 and living in these changing, challenging, transformational times.

I am also one of the oldest and longest actively practicing psychiatrists and psychotherapists in Georgia. The past 40 years have been exciting and tumultuous times, and I'd like to comment on some of my professional and personal observations and experiences.

## Professional Reflections

**W**hen I first came to Georgia in 1946, I was fortunate to be mentored over the 15-month period of my internship at Emory University Hospital by Dr. Lawrence Wool-

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**As inspiring as President Kennedy's mandate for a revolutionary change in the concept and delivery of helping services through community centers was, the enthusiasm and interest in the programs gradually faded after his assassination in 1963.**

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ley who was the professor of psychiatry at Emory. He came to Emory from the School of Medicine at the University of Maryland in Baltimore where he also happened to be a favorite teacher. Then, in 1947, I became the first psychiatric resident at Emory and came under the mentorship of John Warkentin and Carl

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Dr. Maholick has retired recently. He resides at 2070 Six Branches Dr., Roswell, GA 30076.

Whitaker who were brought to Atlanta by Woolley to direct the psychiatric department. Later, I did a stint in the service on the psychiatric wards of Oliver General Hospital in Augusta. Afterwards, I left for a psychoanalytic exposure at the Riggs Center in Stockbridge, Massachusetts, following which I returned to Georgia as the first full-time psychiatrist and director of Georgia's first Mental Health Clinic in Savannah in 1950.

At that time, there may have been 15 psychiatrists, 5 to 10 clinical psychologists, and perhaps a handful of psychiatric social workers in this state. There were two small private hospitals, one University Hospital Clinic, one enormous state hospital, and two or three small understaffed outpatient public health mental health clinics.

In a recent count of the services and facilities available in the Atlanta metropolitan area alone, I found there were some 328 psychiatrists, over 200 psychologists, some 40 or more clinical social workers; more than 20 general, private psychiatric and specialty hospitals; numerous community mental health and other types of

outpatient clinical facilities; plus probably hundreds of allied and other alternative practitioners selling their services to the public, to say nothing of the myriad of self-help groups. The extent to which the public has accepted, sought out, and developed all manner of personal, emotional, and mental health resources and services is phenomenal.

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**We as a society have gone through extraordinarily tumultuous times, moments of great despair and high exhilaration, with the underlying, knowing dread that we had unleashed atomic power with the capability of planetary destruction.**

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**W**hen I first ventured into private practice in Columbus, Georgia, in 1952, I had very little support, with a few notable exceptions, from my medical colleagues and meager acceptance from the general public. Referrals were few and far between initially, so that after a year I was about to quit and leave for a salaried clinical position. Most of the early patients I saw were acute or chronic schizophrenics who were not very welcomed by anyone and were not especially amenable to outpatient psychotherapy, which was my major interest. The few who were good candidates for therapy were also very poor and had difficulty paying a fee, which was \$25 per session at that time. No insurance coverage was available for any kind of psychiatric service, in or out of the hospital. I

saw very few men — probably three to four women to each man, and that 3:1 ratio prevailed overall through the years until the 1970s. Now I see an equal number of men and women.

In the late forties and early fifties, there really were no effective chemotherapeutic interventions. There were no antipsychotics, neither to treat schizophrenic nor manic depressive disorders. There were no antidepressants, no safe, reliable antianxiety drugs. I was on the scene participating in and observing the development of all of our current drug armamentarium, which is now extensive and growing. I remember the splash made by Miltown (meprobamate), the first of a new class of antianxiety drugs, and how it was touted as being the answer to the world's tensions. I recall the excitement of using Rawolfia, the Indian root drug that was first used to reduce hypertension and then to treat schizophrenia, as the precursor to the phenothiazines. I was among the first, so I was told, to use Tofranil (imipramine) in the southeast for depression and in the early sixties was already using it as a conjunctive therapy in working with obsessive/compulsive and phobic disorders. I remember having found a legitimate source of supply of Lithium in England and using it on a few brave individuals with manic-depressive disorders before the drug was approved for marketing in the United States.

There were no psychotherapeutic hospitals in our area and less than a dozen of such in the world. Later, as the founding medical director of the Bradley Center in Columbus, I added our institution to that illustrious list of hospitals focusing on a multi-disciplined psychotherapeutic milieu approach for long-term difficult cases, even though we also saw short-term ones. However, in the early fifties, I had to refer to out-of-state resources those individuals needing longer term hospital care and treatment. Those patients in need of acute short-term hospitalization were admitted to the medical wards of the three local general hospitals. Frequently, I used a chemically-in-

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**We are more willing to go to court to sue each other, as we become increasingly litigious which, according to some, is one of the early signs of moral, ethical decay in a society.**

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duced regressive deep sleep relaxation regime for 2 to 4 days and with some remarkably good results. There were no private interviewing rooms for psychotherapy. The patient's room if he or she were alone, the nursing station, the ward pharmacy or kitchen, the stairwell or hallways frequently were used for talking sessions.

**O**riginally in 1952, I went to Columbus chasing a dream whereby the Public Health Department planned to establish a community-wide mental health program, the focal point of which was a series of group workshops in human relationships. These were designed to help individuals to understand self, enhance awareness, improve interpersonal dialogue, promote a sense of safety and security, and diminish interpersonal boundaries. In this context, these were not therapy groups. Rather, the workshops were educationally oriented experiences more focused on health than illness. They were not presented as substitutes for clinical services. These workshops in human relations were offered to the public at large as well as to agencies and institutions. The format for the group work had been tried extensively and successfully in Savannah and a few small communities in southern Georgia in 1950 and was surprisingly accepted quite well. About 100 workshops were conducted with some two thousand "normal" individuals over a period



of some 18 months in Columbus. Unfortunately, the chief executive of the sponsoring institution withdrew support, and the ambitious, unique community mental health program died.

The workshops were almost always powerful, intense, moving experiences for the participants. Sharing, caring, and safe intimacy, were achieved. New interpersonal dimensions were possible between persons.

What was interesting to me was the fact that a few professionals in the public health mental health field were already interested, in the late forties and early fifties, in prevention and the promotion of health or wholeness. They were not solely preoccupied with "dis-ease," as was the tradition or custom, but more concerned with finding ways and means of achieving and maintaining "ease" or wholeness. But treatment issues were the interest and concern of both the buying public and providing professionals.

A major breakthrough for mental health services came with the 1960 election of President Kennedy who championed a nationwide revolutionary change in the concept and delivery of helping services through local, community-based mental health centers. His program, however, was to be founded not only on the provision of treatment services but was to include programs of education, prevention, consultation, and the like. Unfortunately, in the end, the delivery of these later services was at best minimal and even neglected, and some 20 more years had to elapse before these ideas were actively implemented. I was fortunate to participate in that change process, as I was then serving as a consultant to the National Institute of Mental Health regional office in Atlanta. As inspiring as Kennedy's mandate was, the enthusiasm and interest in the programs gradually faded after his assassination in 1963.

In the private sector, insurance coverage was becoming available and first provided for inpatient psychiatric hospital treatment and then later slowly covered outpatient office psychotherapy. This shift in in-

surance coverage made it possible for thousands to obtain psychotherapeutic services, stimulating an explosive development of mental health services at the community level. However, as costs for all health delivery services have continued to rise, serious questions have been asked about its cost effectiveness. As a result, we are now beginning to move in the mode of "an ounce of prevention." What a few years can do to our shifting perceptions!

**T**he last several years especially have witnessed a major shift in consciousness regarding our health and well being. We are encouraged and accepting of increasing individual responsibility for maintaining a healthy body, mind, and spirit. We are increasingly aware of what we eat and what we take into our

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**With the restrictions being imposed by insurance coverages, the practice of psychotherapy, at least as I have known it, may cease to exist or at least be markedly curtailed.**

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bodies, especially tobacco, alcohol, and drugs. We are more focused on regular aerobic exercises in many forms for all ages. And some of us meditate, learn Yoga, Tai Chi, and the like. We are more nutritionally sensitive than ever before. We have become very interested in wellness clinics, longevity and living centers, and attend all manner of workshops and seminars that promise enhancement and wholeness of our being.

During these same years on the broader mental health scene in

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**By the mid seventies, I found myself slowly, subtly, increasingly drawn to matters of the spirit — internal space.**

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Georgia, we witnessed an exposé of Milledgeville State Hospital and its removal from the Welfare Department to the Public Health Department and later the establishment of a separate Department of Mental Health and Mental Retardation. In place of the singular state hospital, several smaller regional state hospitals were developed. During the Carter administration, more reforms were instituted, and the mental health programs were dismantled and reorganized, redefined, and restructured. While large numbers of patients have been discharged from the state and regional hospitals, and with major emphasis on short-term treatment, we are now seeing increasingly large numbers of acute and chronic dysfunctional/psychotic individuals accumulating in the local community — everything changes while things remain the same.

#### **Personal Reflections**

**F**or my part, during those years I worked as a consultant at one time or other to a host of community agencies and institutions, helped several communities in Georgia and Alabama develop bud-

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**One physician's reflections on his life, profession, society, and world.**

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ding mental health programs, wrote, gave speeches, and conducted workshops, supervised, trained several hundred doctors, ministers,



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**What was interesting to me was the fact that a few professionals in the public health mental health field were already interested, in the late forties and early fifties, in prevention and the promotion of health or wholeness.**

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lawyers, nurses, and caseworkers in mental health counseling methods. As Medical Director of the Bradley Center in Columbus, I was responsible for its continuing development for 18 years (1955-1973), first as a private non profit multi-disciplined outpatient community mental health center and then later in 1968 also as a psychotherapeutic hospital. Also during this time, I was engaged in a large and active clinical practice.

After my second "burn out" at the height of my career, at age 51 in 1973, I resigned. I was, at that time, in the process of developing a new facility, the House of Haelon (wholeness), located across the street from the hospital and outpatient treatment facilities. This facility was to develop programs in education for living and was intended to bridge the gap between "dis-ease" and "ease" — illness with wellness. Its focus was to be on education, prevention, and the promotion of health. However, I left Columbus before that was implemented and moved, in pain, to Atlanta where I started all over again, focusing primarily on clinical practice.

By the mid seventies, I found myself slowly, subtly, increasingly drawn to matters of the spirit — internal space. This interest culminated in the formation of the Institute for the Art and Science of Living and the sponsoring of a

weekend seminar and workshop: New Dimensions of the Mind, Exploration through Science and the Spirit in March, 1980, at the World Congress Center in Atlanta. Some of the most brilliant, leading-edge thinkers representing such diverse fields as mathematics, physics, music, philosophy, mysticism, martial arts, psychology, and analysis gathered, addressing the same issues, but from their varying perspectives. It was an exciting, exhilarating, and stimulating venture. Unfortunately, it also was a total disaster for me financially, since so few attended — more coming from out of state than Atlanta itself.

### **Societal Reflections**

During these last 4 decades, we as a society have gone through extraordinarily tumultuous times, moments of great despair and high exhilaration, with the underlying, knowing dread that we had unleashed atomic power with the capability of planetary destruction. Another grand dream of international understanding, cooperation, and peace manifested itself in the formation of the United Nations. But as the League before it, it, too, became impotent as wars continued unabated, and the organization became a major platform for oppositional power politics and manipulations.

There was Sputnik. Humankind was released from its ties to our earth home, and we engaged in increasing exploration of outer space and the universe, culminating in man's landing on the Moon. We in the USA moved beyond industrial productivity into the technologic informational age and from a local national economy to a global international one. Disease, illness, and disability were being conquered, as was Mount Everest and the depths of the oceans.

A couple of major wars excited and tormented us. The world of electronics exploded, and we are now in instant touch with people and events around the world. Computers are impacting us in our work, economic, social, and individual

worlds. Major social changes excited us, nearly tore us apart, and stimulated us to create new ways of viewing and visioning our world.

There were the civil rights movement, the hippie movement, the feminist movement, and the advent of gay rights. We became more consciously aware of the extent of human hunger world wide. There were the anti-Vietnam demonstrations and now the anti-nuclear groups. More recently, the anti-abortion groups became more visible and vocal. And we are more willing to go to court to sue each other, becoming increasingly litigious which, according to some, is one of the early signs of moral, ethical decay in a society.

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**In another arena of clinical care, third party payers have all but eliminated long-term intensive psychotherapeutic hospital treatment simply by defining the limits of hospital days and/or dollars the coverage will provide.**

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The self-help groups have increased enormously in numbers and diversity. Sexual attitudes and behaviors were profoundly liberalized as were divorce laws, and we went on a "free sex" and divorce spree.

The traditional family image has been assaulted from all sides. More people are living as single units. There are more single parent families and mixed and extended families. Many individuals think in terms of support groups and networking in lieu of and in addition to traditional family ties and units. Increasingly, there are two income workers — career track families.



And sadly, perhaps partially as a result of the above, there are more emotionally disturbed youngsters, particularly adolescents, than ever before.

We've gone through the age of anxiety, the age of depression, and currently we are heavily into the age of addiction. The latter seems to have come about with our considerable national focus on alcohol, drugs, and cigarette abuse. But we've expanded those horizons to encompass the way we abuse food, sex, work, gambling, and even love as a manifestation of addiction. Most recently, the devastating potential of a panepidemic of AIDS terrifies our world. AIDS may well be heralding in a host of new immune deficiency diseases.

At the same time, we've also become an increasingly more informed, better educated, more sophisticated, richer, culturally diversified, more open and direct, a more sharing and caring society, and have increasing options at our disposal. We also have become interested and concerned about the well-being of our planet, its environment, and the people living on its surfaces. While concurrently we are also more scared, frightened, suspicious, defensive, and aware that we can more totally destroy ourselves than ever before in our whole history. And at the same time, we are moving in a direction of desiring to live more peacefully and harmoniously with all peoples. And increasingly, we think more in terms of compromise rather than combat to resolve our differences.

**L**ooking from another perspective with regard to the practice of medicine, we have experienced enormous shifts from the highly individualized private practitioner to its current increasing commercialization. We've moved from the small solo practitioner to partnerships and group practices to professional corporations, mega groups, HMOs, IPAs, PPOs, and other alternative health care systems. For whatever reasons, we've allowed ourselves to be shorn of much of our profes-

sionalism by third parties whose primary interests have been profits. Medicine is just another product to be dispensed and maintained by service providers. Patients are now consumers who want quality services at the least possible cost. Commercial business managers have, on many levels, moved in to define not only the nature of the product but also its quality, quantity, and how the services are to be dispensed. This has been done, of course, in the name of cost effectiveness (profits).

Perhaps the above is somewhat of an overstated simplification of the situation, and no doubt there have been many instances where both the givers and receivers of services have abused the system. Also, greed, excessive fees, and accumulation of considerable wealth through the practice by some physicians have helped tarnish the im-

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### **We have experienced enormous shifts from the highly individualized private practitioner to the current increasingly commercialization.**

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age of doctors and medicine. This is not to say that physicians aren't worthy of a very good standard of living and a good return on their total and considerable investment. They work hard, have long hours, and carry heavy responsibilities and demands.

#### **More Professional Reflections**

As with the whole of medicine, many significant changes have also taken place in the practice of psychiatry. In the early years of institutional and hospital psychiatry, physicians and psychiatrists played

major responsible roles in providing both direct clinical care and administrative leadership. Also, in the early days of the public health mental health programs in the fifties, psychiatrists provided a major share

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### **We have also become an increasingly more informed, better educated, more sophisticated, richer, culturally diversified, more open and direct, a more sharing and caring society. . . .**

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of clinical and administrative duties. This was even true in the sixties at the beginnings of the community mental health centers' movement. However, psychiatrists gradually withdrew and moved increasingly to private practice, especially as insurance coverage expanded to include mental health services. The void created by this exodus was filled at all levels by other professionals, notably clinical psychologists and psychiatric social workers. It has been interesting to see that as private practice opportunities became increasingly available to them, many of the psychologists and clinical social workers also have withdrawn from the institutions and centers. In fact, it is now possible in some systems for anyone with a bachelor's or master's degree to administer programs and provide direct clinical services. Health insurance companies are also moving in the direction of legitimizing a wide spectrum of clinical caretakers/service providers. This movement may be legitimate in the name of cost effectiveness (profits), but how aware is the buying public of what it is that is being purchased?



**I**n another arena of clinical care, third party payers have all but eliminated long-term intensive psychotherapeutic milieu hospital treatment simply by defining the limits of hospital days and/or dollars the coverage will provide. Emphasis currently is placed on short-term hospital treatment, with symptomatic relief as a primary goal, and then a discharge back into the community and outpatient care. Frequently, this process has much merit and is quite appropriate. However, outpatient psychotherapy also has been curtailed, by limiting the number of sessions allowed per year or by limiting the annual dollar amount permissible for therapy, or by defining the percentage of the usual and customary charges payable or a combination thereof. Again, the consumer probably doesn't know about these limitations until the services are about to be utilized.

On the one hand, there is the promise of broad mental health services, while in practice they are greatly restricted and limited. Unfortunately, it may take several decades before the public at large becomes fully aware of the illusionary nature of the promise and demand changes.

### **Professional Projections**

Meanwhile, with the restrictions being imposed by insurance coverages, the practice of psychotherapy, at least as I have known it, may cease to exist or at least be markedly curtailed. It may not soon be possible for responsible individuals to utilize individual psychotherapy to explore the world of internal space — thought, feelings, fantasies, images, dreams, and the like — to achieve a depth of understanding of self and others and acquire an inner sense of well being — inner health, if you will.

If health insurance carriers will only provide for short-term counseling focused primarily on symptomatic or dysfunctional relief, or acute problems of living or other

life situational crises, psychiatrists may well leave the field of necessity to those other service providers so designated by insurance payers or alternative care systems who will accept a lesser monetary return for their work. Of course, some psychiatrists may be quite willing to work for less money. Then again,

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### **I remember the splash made by Miltown, the first of a new class of anti-anxiety drugs, and how it was touted as being the answer to the world's tensions.**

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the insurance carriers may eliminate the necessity for all service providers simply be defining the above human needs as "normal" or at least "non diseases," therefore nonreimbursable. As mentioned elsewhere, it may take a decade or more for public consciousness to be raised to the level of awareness about the unavailability of long-term psychotherapy and demand better, more comprehensive psychotherapeutic coverage.

**I**n the midst of the above machinations, with the explosion of knowledge and interest in mind altering drugs and states of consciousness, the world of biological psychiatry has come upon us. Many psychiatrists are moving into this area as a specialty. Here there appears to be greater focus on symptoms and complaints and less interest in talking, listening, or dialogue. The objective is to get a clear enough picture of how the brain and body are dysfunctional so as to be able to prescribe the appropriate drug or drugs to correct

the malfunction and effect symptomatic relief and then follow. In this sense, psychiatry may become more connected to the traditional practice of medicine.

If talking and listening and sharing and caring are not of any great significance or substance (I believe they are) — and prescribing mind altering drugs are (I do believe they have value), then we are rapidly approaching the point where it just might be possible to do away with both talking and prescribing psychiatrists. Even now with our computer potential, I can visualize a consumer going into a local pharmacy, grocery/produce center, or even a 7-11 store equipped with a mental health computer booth, sit down and take a psychological diagnostic test and punch out his or her symptoms and complaints. In a few minutes, the consumer receives a printout describing his or her psychological profile along with strengths and weaknesses plus a detailed analysis of the problem or problems, the options to be exercised to resolve the problems, and when indicated, dispense the appropriate drug with instructions accompanied by a list of side effects. An itemized statement with total cost is given. A credit card is inserted, the insurance form is completed, and is automatically forwarded to the insurance company. Who needs any mental health service provider! And maybe that's really not so far off the mark.

It is my own personal belief that my professional existence as a psychotherapist is an artifact — a reflection of the void that exists in our society in our times. I do what people can do but don't — talk, listen — listen until the other can hear, share, and care. Talk the untalkable. Feel the unfeeling. Think the unthinkable. Explore the invisible, but knowable, inner space. Until the centerpoint of calm — of silence — is found and experienced. When all of humanity comes to that place, not only shall we not need any psychotherapists but we shall all be linked hand to hand and heart to heart, living in harmony — in love — with ourselves, each other, and our planet — we are the world!



# Peer Review in the 1990s

## A Look at the Georgia Medical Care Foundation

Ralph A. Murphy, M.D., Tom W. Williams, C. Patrick Ryan

### Introduction

**B**Y NOW, we are all familiar with the concept and practice of physician-sponsored peer review activities, particularly as they relate to government-funded health care delivery systems, i.e. Medicare and Medicaid. As health care expenditures continue to increase and concerns for quality of care intensifies, the federal government has stepped up its efforts to monitor physicians and hospitals. Interestingly, the programs seem to be focusing more on information sharing and education rather than the more punitive actions such as monetary penalties and sanctions.

In this and subsequent issues of the *Journal*, we will attempt to highlight the major aspects of the federal Peer Review Process and its implications for physicians in Georgia. As the first of a three-part series, this article will summarize the major types of review activities required and provide an overview of the actual medical record review process. The second article will

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cover the expanded review of invasive surgical procedures in both the inpatient and ambulatory settings. In a final article, we will discuss the Georgia Medical Care Foundation's (GMCF) quality intervention plan. This plan will be the central focus of GMCF activity during the present contract and will

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require the involvement of practicing physicians throughout the state. Although the Program is funded from Washington, DC, the PRO statute is clear in that the decisions are to be made by "local peers." The Quality Intervention Plan is GMCF's proposal for ensuring review by "local peers."

### Background

Before describing the salient aspects of the Peer Review Program for the period of April 1, 1989 — March 31, 1992, it is appropriate to briefly describe GMCF's background and its role in peer review activities in Georgia during the past 20 years.

The GMCF was created by MAG in October, 1970, as a physician-sponsored non-profit medical peer review organization to meet the emerging demand for utilization management services from industry and government. GMCF was involved in the Experimental Medical Care Review Organization (EMCRO) which began in 1971.

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## **GMCF is a peer review program funded by Medicare but implemented by Georgia physicians with a primary focus on quality review.**

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Soon after that, the Professional Services Review Organization (PSRO) came on the scene. In 1984, this was followed by the Utilization and Quality Control Peer Review Organization (PRO). As Medicare programs expand and costs of services escalate, the federal government continues to try to devise ways to control utilization and to ensure quality of care.

The majority of physicians appear to support the idea of medical peer review by appropriate specialists, with adequate appeals and safeguards, as the best way to provide the needed controls. That continues to be GMCF's primary purpose.

Currently, GMCF's membership elects 20 practicing medical doctors from 10 districts throughout the state to its Board of Directors. There are also 2 osteopathic physicians, 2 dental specialists, and 1 representative each for Medicare beneficiaries, CHAMPUS beneficiaries, the Georgia State Medical Society, the Georgia Health Care Association, and the Georgia Hospital Association.

GMCF has evolved into three major divisions as follows:

PRO Contract — Medicare  
(1981 — Present)

Nursing Home Review —  
Medicaid  
(1973 — Present)

Physician Services Review —  
Medicaid  
and Private Insurance Companies  
(1971 — Present)

### **PRO Required Activities**

As the Peer Review Organization in Georgia for the period April 1989 - March 1992, GMCF will be continuing most of its in-patient hospital reviews and implementing several review programs in other settings. In addition, we have recently initiated review of hospital admissions reimbursed by the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). Overall, GMCF will be conducting approximately 125,000 reviews each year. Approximately half of those reviews will be retrospective chart review of hospital admissions. Forty percent will involve procedure review in both hospital and ambulatory setting (note — most procedure review is conducted by phone, prior to the procedure). The remaining 10% of review activity includes review of care rendered by Home Health Agencies, Skilled Nursing Facilities, Hospital Outpatient Departments and Health Maintenance Organizations. It is important to note that review in these "other" settings is limited to quality review only, i.e., the The Fiscal Intermediary (e.g., Blue Cross for Medicare Part A or Aetna for Medicare Care Part B) will still be responsible for making utilization (payment) determinations in these settings.

### **The Peer Review Process**

For inpatient reviews, GMCF is required to review each chart in the following areas:

1. Quality of Care
2. Appropriateness of discharge
3. Necessity of admission
4. Necessity of invasive procedure, if applicable
5. DRG validation (i.e., calculation of payment)
6. Coverage (Is procedure covered by Medicare?)

Based on the high volume of cases to be reviewed, GMCF used non-physician reviewers to "screen" cases selected for review. These individuals include Registered Nurses, LPNs, and Registered Records Professionals. Utilizing established criteria, these non-physician

reviewers have the authority to approve any case under review. If a problem/concern is identified by the non-physician reviewer, the cases is referred for review by a GMCF physician consultant.

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## **The important thing to remember here is the role of practicing physicians in the process.**

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The physician consultant does not use the criteria referenced above but rather relies on his/her professional judgment and medical expertise. The reviews are assigned to physicians of the appropriate specialty, who are actively practicing in settings similar to the attending physician. If the GMCF physician identifies a potential problem, a preliminary notice is generated to the responsible party. The notice explains GMCF's findings, requests additional information, and provides up to 30 days for a response.

Upon receipt of additional information, the case is assigned to a second GMCF physician consultant for review. This review is intended to confirm/refute preliminary findings. If a problem is noted, the responsible party is notified and advised of his/her right to request a reconsideration. If a request is received, GMCF will arrange for a review of the case by a third physician of the appropriate specialty.

**I**t should be noted here that quality of care determinations are not subject to appeal at this time; however, all quality issues will be reviewed by a committee of GMCF physicians before any further action is taken. We will be discussing the specifics of the Quality Intervention Plan, including the release of information, in a later article.



The important thing to remember here is the role of practicing physicians in the process. Based on recent efforts to involve more physicians, we have received commitments from over 700 colleagues from around the state. We are presently credentialing many of those physicians and plan to incorporate them into their peer review process. We have also opened offices in Savannah and Tifton to accommodate the physician consultants. Success in this area translates into a more broad-based review program with a more equitable distribution of the workload throughout the state.

In addition to these review activities, GMCF is required to conduct meetings with physicians and providers to discuss peer review findings. These meetings will include statewide and regional sessions as well as conferences with individual providers, as requested.

These information-sharing sessions are essential in any peer review effort, and we look forward to meeting with you.

#### Summary

Although it is not possible to completely summarize all of the policies and procedures of a program as complex as the PRO program in one article (or even three), it is useful for establishing the framework of these activities over the next 3 years. Many of us are skeptical of the government's role in the medical review process, and some of us can recall specific instances where problems, e.g., backlogs, have diverted us from our primary mission — to insure quality care. It is imperative, as we begin this new PRO contract, that we all recognize what the PRO program is and what it is not. Specifically, it is

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### **As the Peer Review Organization in Georgia for the period April, 1989-March, 1992, GMCF will be continuing most of its in-patient hospital reviews and implementing several review programs in other settings.**

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not a program of quotas wherein GMCF is required to produce a certain number of denials, quality problems, sanctions, etc. It is a peer review program funded by Medicare but *implemented by Georgia physicians* with a primary focus on quality review.

A second point that needs to be made here concerns the scope of PRO findings relative to the volume of cases reviewed. As with any quality assurance program, it is necessary to look at many cases to determine if there are problems. It is important to note here that GMCF recognizes that most health care delivered in Georgia is appropriate. In fact, Mr. Thomas Morford, National PRO Program Director of the Health Care Financing Administration, recently testified to Congress as follows "clearly, the most important observation thus far is that the PROs have not uncovered any systemic quality problems in the

Medicare program. The instances of substandard quality found by the PROs have been isolated and do not indicate a trend towards a program-wide deficiency in the quality of hospital care. This is a significant finding, because it indicates that the vast majority of physicians and hospitals in this country practice high quality medicine." GMCF's findings during the past 3 years corroborates Mr. Morford's testimony.

Our mission, therefore, is to continue to refine our procedures for identifying aberrancies. We must continue to work to minimize disruptions to providers who are delivering quality care. In this regard, review levels in each hospital have dropped from a high of 40% of all admissions in 1986 to approximately 15% in 1989. We will continue to monitor these levels to focus our resources in the areas of greatest need.

Finally, PROs are repositories of large amounts of data that can be used effectively to assist physicians and providers in the management of their own utilization/quality assurance systems. During this contract, we will be working with you to identify the types of information that should be shared and the format for distributing same. Obviously, strict adherence to established confidentiality regulations is essential in all disclosures.

It is incumbent that physicians, providers, and GMCF work together in the coming months to establish an effective information exchange system which will protect an individual's right to privacy and yet provide useful information to all.

NEXT MONTH:

PRO REVIEW: SURGICAL REVIEW  
ACTIVITIES

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# Physician Supply and Distribution in Georgia

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Over the past several years, physician demand and supply in the United States has been subjected to close scrutiny.<sup>1</sup> The Graduate Medical Education National Advisory Committee (GMENAC) has suggested that there will be 70,000 more physicians than are required in 1990, followed by surplus of 150,000 physicians by the year 2000.<sup>2</sup> A recent study by Schwartz, et al.,<sup>3</sup> however, suggests that GMENAC's prediction of a massive physician surplus will not occur and that, in fact, there will be a need for physicians by the year 2000. After considering several pertinent and critical assumptions, the authors state that "there will be no surplus in the year 2000; in fact, our best estimate is that demand will exceed supply by some 7,000 physicians." It is our contention that we are facing a similar but more serious situation in Georgia, one in which there will be a substantial need for physicians by the year 2000. The purpose of this paper, therefore is to describe current and future characteristics of the physician supply in Georgia.<sup>4</sup>

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**Trends in physician supply are not easy to determine. It is very difficult for individuals and associations to agree on the most appropriate method for determining physician supply.**

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## Georgia's Physician Supply

In 1986, there were 8,975 physicians providing care to Georgians. This represented a physician-to-population ratio of 148/100,000 population. Table 1 depicts physi-

cian supply by county population groupings, MSA, and Non-MSA over time. The data clearly demonstrate a situation where Georgia is well below the GMENAC standards in almost all geographic subdivisions of the state. Clearly, the least populated counties and the Non-MSA areas experience the lowest physician-to-population ratios. More specifically, counties with population from 0-9,999 and 10,000-19,999 along with the central Non-MSA area have the lowest physician supply. Given the current under-supply of physicians in Georgia, what can we expect by the years 1990 and 2000?

Trends in physician supply are not easy to determine. It is very difficult for individuals, organizations, and associations to agree on the most appropriate method for determining physician supply. However, if the physician population continues to grow, not at an average annual rate of 336 (as determined from AMA data),<sup>5</sup> but at an increasing rate (as evidenced in the 1978-1985 period), we estimate that more than 400 physicians will be added each

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TABLE 1 — Total Physicians, by Number and Rate,\* County Population Groupings, MSA, and Non-MSA Georgia 1968, 1980,\*\* 1986

Category	1968		1980*		1986	
	#	Rate	#	Rate	#	Rate
County Population						
0 - 9,999	—	—	104	32.2	98	38.0
10,000 - 19,999	—	—	381	50.6	382	51.0
20,000 - 49,999	—	—	1,023	90.6	965	75.0
50,000 - 149,999	—	—	1,112	128.4	1,405	127.0
Over 150,000	—	—	5,688	237.8	6,024	227.0
State Total†	5,247	118.9	8,308	152.1	8,975	148.0
MSA						
Albany	80	94.0	145	129.0	159	127.0
Athens	107	82.4	209	114.5	189	133.0
Atlanta	2,534	164.3	4,147	198.8	4,557	185.0
Augusta	569	307.4	878	365.4	945	349.0
Chattanooga	33	36.4	53	50.1	55	49.0
Columbus	208	140.2	312	162.6	298	148.0
Macon	259	112.6	386	146.4	418	147.0
Savannah	239	123.8	406	184.1	393	167.0
MSA Total	4,029	154.7	6,536	192.1	7,014	183.0
NON-MSA						
Northwest	315	69.5	483	91.5	508	90.0
Northeast	147	65.8	250	93.7	273	95.0
Central	324	69.1	345	70.6	364	69.0
Southwest	227	63.5	336	85.2	348	82.0
Southeast	205	66.9	358	93.4	367	87.0
Non-MSA Total	1,218	67.3	1,772	86.0	1,860	84.0
State Total	5,247	118.9	8,308	152.1	8,975	148.0

\*Rate is per 100,000 population and is rounded to nearest whole number.

†Total will not equal the sum of all population groupings because of unknown county of practice (98.9% of all physicians completed the category "County of Practice").

MSA = Metropolitan Statistical Area; Non-MSA = Non-Metropolitan Statistical Area.

\*\*\*"A Study of Health Manpower in Georgia" (April 1985) reports on physician data collected in 1980. These data did not exclude retired or out-of-state physicians. Any comparison, therefore, between 1980 and 1986 data should be made with extreme caution.

year to Georgia's physician supply. Thus, by 1990, we would add 1,600 new physicians while losing 1,025 due to retirement. This computation results in a net gain of 575 physicians. Due to the expected population growth, however, the 1990 physician-to-population ratio would remain unchanged from 1986 — 148.1/100,000 population.

In the year 2000, the situation is projected to be quite similar. By 2000, we expect to add 5,600 new physicians while losing 2,651 due to retirement — a net gain of 2,949 physicians. The resulting physician-to-population ratio of 160/100,000 is still well below the 1990 GMENAC standard of 191.4/100,000. The 1990 and 2000 supply of primary care specialties and the requirement for each is shown in Figure 1. The two primary care specialties which will be in the greatest demand are family practice and in-

ternal medicine.

The projected rapid growth in Georgia's population is a major factor impacting on the apparent future shortage of physicians. We are

**A recent study suggests that GMENAC's prediction of a massive physician surplus will not occur and that, in fact, there will be a need for physicians by the year 2000.**

expected to grow from 6 million in 1986 to 6.5 million in 1990, and to

7.5 million by the year 2000; another critical factor is the number of physicians who will retire by the year 2000. These two factors are major determinates to the future overall physician supply. A more critical and certainly more urgent issue however, is the problem of maldistribution.

#### Maldistribution

There is a maldistribution of physicians in Georgia. With regard to the total numbers of physicians, this fact is not new. However, for the first time in 1986, major maldistribution trends are emerging among primary care providers. To illustrate, Table 2 depicts primary care physicians by county population groupings and MSA/Non-MSA groupings. With the exception of family practice, all other primary care specialties become more prevalent as a county's population in-



**TABLE 2 — Physicians By Specialty, Number, and Rate\* County Population Groupings, MSA, and Non-MSA, Georgia 1986**

Category	Family Practice		OB/GYN		Pediatrics		Internal Medicine		General Surgery		Other Specialty		Total Physicians	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
<b>COUNTY POPULATION</b>														
0 - 9,999	60	24	2	1	4	1	8	3	6	2	16	6	98	38
10,000 - 19,999	210	28	14	2	10	1	44	6	32	4	66	9	382	51
20,000 - 49,999	268	21	73	6	62	5	125	10	88	7	340	26	965	75
50,000 - 149,999	213	19	108	10	98	9	187	17	109	10	680	61	1,405	127
Over 150,000	580	22	381	14	462	17	1,143	43	330	12	2,983	113	6,024	227
Total†	1,344	22	579	10	641	11	1,517	25	566	9	4,113	68	8,975	148
<b>MSA</b>														
Albany	18	14	14	11	9	7	19	15	12	10	84	67	159	127
Athens	33	23	14	10	11	8	17	12	13	9	100	71	189	133
Atlanta	441	18	281	11	377	15	895	36	255	10	2,208	90	4,557	185
Augusta	78	29	60	22	77	28	192	71	45	17	462	170	945	349
Chattanooga	20	18	5	4	2	2	5	4	5	4	18	16	55	49
Columbus	54	27	24	12	15	7	40	20	22	11	138	69	298	148
Macon	81	29	36	13	24	8	51	18	29	10	191	67	418	147
Savannah	51	22	28	12	20	9	60	26	30	13	197	84	393	167
Total MSA	776	20	462	12	535	14	1,279	33	411	11	3,398	89	7,014	183
<b>NON-MSA</b>														
Northwest	141	25	35	6	25	4	68	12	38	7	195	35	508	90
Northeast	74	26	14	5	17	6	36	13	20	7	108	38	273	95
Central	132	25	17	3	45	9	45	9	33	6	117	22	364	69
Southwest	99	23	24	6	21	5	38	9	33	8	132	31	348	82
Southeast	109	26	26	6	24	6	41	10	30	7	135	32	367	87
Total Non-MSA	555	25	116	5	101	5	228	10	154	7	687	31	1,860	84
Total State	1,344	22	579	10	641	11	1,517	25	566	9	4,113	68	8,975	148

\*Rate is per 100,000 population and is rounded to nearest whole number.

†Total will not equal the sum of all population groupings because of unknown county of practice (98.9% of all physicians completed the category "County of Practice").

MSA = Metropolitan Statistical Area; Non-MSA = Non-Metropolitan Statistical Area.

creases. The rate of family practitioners remains relatively stable regardless of county population.

Of the MSA regions, Augusta maintains the highest rates across all primary care specialties. Again, the central Non-MSA region has rates consistently lower than other Non-MSA regions except in the specialty of pediatrics in which it has the highest Non-MSA rate.

Sixty-eight percent of all physicians are located in nine counties which collectively comprise 44% of the state's population. Of all physicians located in counties exceeding 20,000 population, only 13% are family practitioners. To compare, this specialty represents 57.2% of all physicians practicing in counties with less than 20,000 residents.

### Physician Demographics

Demographic characteristics of physicians are critical to the understanding of physician manpower planning. Several major de-

mographic trends will influence the practice of medicine in years ahead. Because of the "baby-boom" generation, several age groups will increase in number while others decrease. These fluctuations will require increases in some physician specialty practices, whereas other changes in age cohorts will have a negative impact. The most pronounced trend which will increase the need for physicians will be the growth in the population over age 65.

### Age Characteristics of Physicians

Variation in the average age of physicians by specialty is not very pronounced. The youngest average age is 44 (internal medicine) and the oldest 50 (general surgery). The average age of all physicians increases with the degree of ruralness, i.e., older physicians are in the most rural areas — county population groupings of less than 10,000.

Analyzing numbers of physicians by selected age groups reveals much more relevant information. Thirty-two percent of all physicians are in the 35-44 age group — the highest percentage for all age groups. This pattern is identical for both black and white physicians. The second highest percentage of all physicians (26%) is in the 55 or older age group. Essentially, this means that slightly more than one-fourth of all physicians will reach retirement age (65) by the year 2000. Not all physicians retire at age 65, however, as evidenced by the fact that 9.2% who are over 65 are still practicing.

### Race and Sex Characteristics

Data relative to race and sex indicate maldistribution, with fewer black and women physicians. As more women and blacks are admitted into medical schools, this maldistribution may eventually be adjusted. Currently, 87.9% of all

physicians are white, and 4.7% are black; however, there are more minority group physicians than blacks (7.4%).

The geographic distribution of physicians by sex is quite unequal. The male to female ratio is 8.3; for MSAs it is 7.5, whereas for Non-MSAs the ratio is 12.7.

Data relative to sex and specialty show that women are attracted to pediatrics, obstetrics/gynecology, and internal medicine as their top three career choices. Their predominant choice is pediatrics; women represent 26.7% of all physicians who select pediatrics as a specialty. In absolute numbers, women do choose other specialties; however, they represent only 8.4% of all physicians in this category.

### Supply and Distribution of Foreign Medical Graduates

In the United States, including Georgia, the majority of physicians are U.S. medical graduates (USMGs). In 1986, 1.5% to 7% of all residents were foreign medical graduates (FMGs). In Georgia, 13.6% of all physicians were FMGs. By their tendency to locate in rural areas, FMGs provide an extremely valuable service in alleviating the needs of many of the medically underserved areas in the state. In Georgia, FMGs account for 12.7% of physicians in the MSAs, and 17.1% in the Non-MSAs. Further, there is an inverse relationship between the percentage of FMGs and the degree of urbanization, with the percentage of FMGs decreasing as

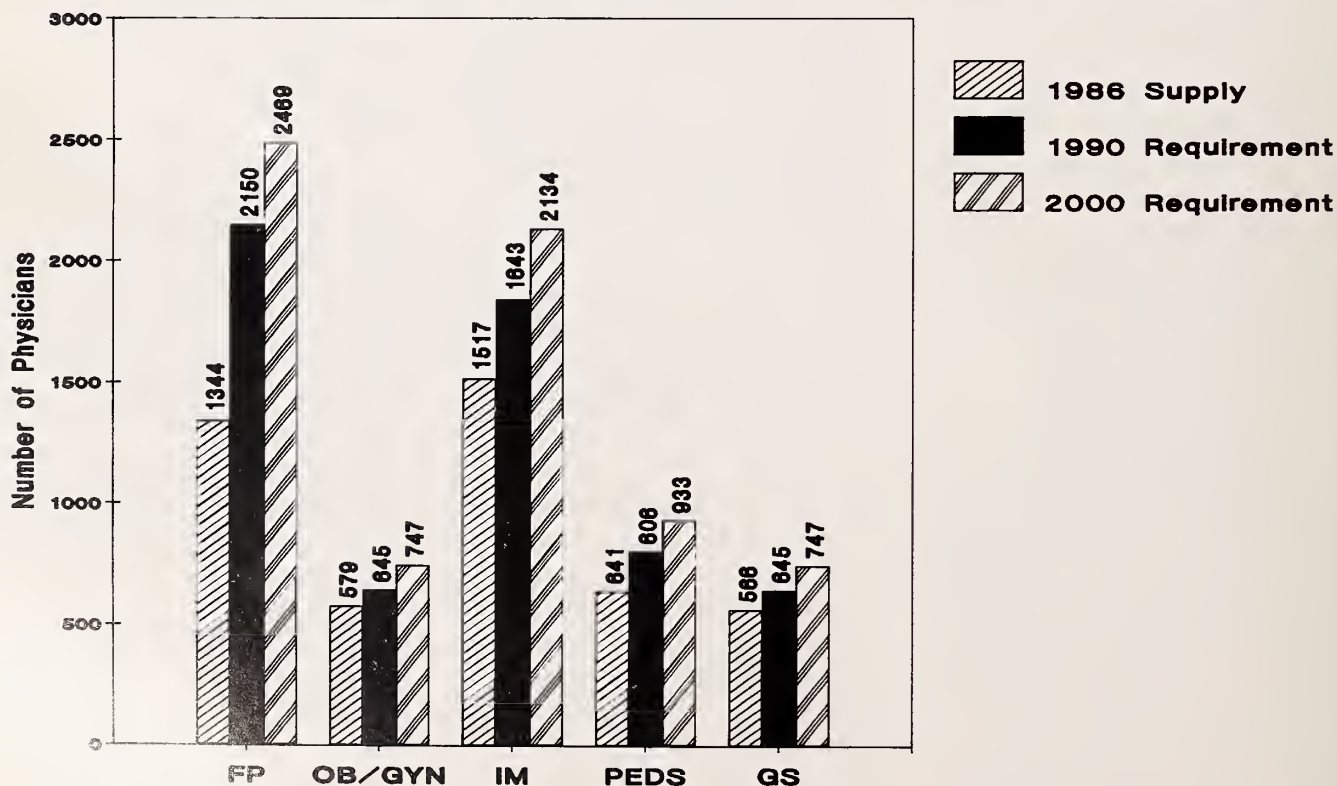
an area becomes more urban. Although the percentage of FMGs is greater in rural areas, the actual number is greater in populations of more than 150,000.

### Physician Acceptance of Specific Patients

An issue that is of continuing concern to the medical and public health communities is physician acceptance of Medicaid, Medicare, and obstetric patients.

It is conceivable that the percentage of physicians accepting these types of patients could be improved in Georgia. Of responding physicians, 71.2% accept Medicaid patients and 83.8% accept Medicare. Among the physicians participating in Medicaid, there is great

## Supply vs. Requirement \* Primary Care Physicians, Georgia, 1986



\* Requirement Based on GMENAC Report, 1980.



variation by specialty. Percentages range from 52% of all obstetricians to 84.6% of all general surgeons. For physicians participating in Medicare, there also exists a range of participation among specialties. General surgeons and internists have the highest percentage, at 95% and 92%, respectively. Predictably, pediatricians express the lowest percentage (31.6%) as they generally do not care for the elderly. It should be noted, however, that a solo practicing pediatrician in a rural area may serve essentially as a family doctor, treating all family members regardless of age.

Geographically, acceptance of these patients varies a great deal. For both Medicaid and Medicare, an inverse relationship is seen between urbanization and percent of physicians participation in these programs. In layman's terms, a larger percentage of doctors accept Medicaid and/or Medicare in the more rural areas. Further, the percentage of Medicaid acceptance rates in MSAs is 67.7% and 83.4% in Non-MSAs. There is no essential difference found by comparing MSA and Non-MSA Medicare and obstetric patients.

### Quality of Life

To improve Georgia's physician supply and maldistribution problems, we must begin to improve the overall quality of life in this state. Clearly, education, socioeconomic status, health status, and health access are all factors which relate to quality of life. In most of Georgia's rural areas, many of these factors show a poor level of attainment. High unemployment rates, a high percentage of high school drop outs, lower educational attainment, high numbers of families living below the poverty level, high infant mortality, high death rates from strokes, low physician-to-population ratios and poor accessibility to medical care characterize the overall poor quality of life in rural Georgia.<sup>6</sup>

Notably, the southwest and central sections of the state have major areas where poor quality of life is evident. These areas also correlate

quite well to areas of low physician rates. It is the quality of life which must be addressed if we expect to improve the supply and distribution of physicians in Georgia. We must provide a quality of life which is attractive to physicians and to all citizens of the state.

### Summary

Physician supply in Georgia must be considered an urgent issue. Several important points must be recognized and addressed.<sup>4</sup> The lowest physician rates are in the more rural county population groupings. The only county population grouping with a surplus of physicians is in the over 150,000 population. The majority of physicians are concentrated in the metropolitan counties.

### Among the physicians participating in Medicaid, there is great variation by specialty.

Sixteen percent of all physicians practice in the 134 counties having less than 50,000 population.

The majority of physicians are in primary care specialties. Family practice is the most dominant specialty in rural areas.

By the year 2000, Georgia can expect to add 5,600 physicians due to growth. By the year 2000, Georgia can expect to lose 2,600 physicians due to retirement.

Family practitioners are the most uniformly distributed of the specialties examined. They are also the specialty most needed.

The average age of Georgia physicians is 46. General surgeons are in the oldest average age group (50), whereas internists are in the youngest (44). Older physicians are concentrated in the more rural areas. A significant number of all physicians are over age 55. The majority of these will be retired by the year

### Sixty-eight percent of all physicians in Georgia are located in nine counties which collectively comprise 44% of the state's population.

2000. Physicians over age 65 represent 9.2% of all physicians from the survey.

In Georgia, 13.6% of all physicians were Foreign Medical School Graduates. They tend to locate their practices in medically underserved areas. The specialty choices most frequently favored by FMGs are: pediatrics, internal medicine, family practice, and obstetrics/gynecology. A total of 71.2% of all physicians accept Medicare patients; 83.8% accept Medicaid patients. Ninety-two percent of all obstetricians accept obstetric patients, but this participation is threatened by problems with malpractice insurance.

### Acknowledgements

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## **ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.**



# Why Family Practice Residents Choose Not to Practice Obstetrics

James L. Fletcher, Jr., M.D., Meyer P. Schwartz, M.D.

**D**eclining access to obstetrical/prenatal care is a growing crisis in the United States.<sup>1</sup> According to a survey by the American Academy of Family Physicians (AAFP), more than half of U.S. family physicians (FP) who in the past performed obstetrics (OB) have discontinued the service; of these, about 28 percent cited reasons related to liability insurance/malpractice (LI/M), and about 36 percent cited other reasons. Whereas in 1968 about 31 percent of U.S. deliveries were performed by FPs, now the proportion is probably less than 10 percent.<sup>2</sup> The AAFP has reported that in 1986 alone, about 23 percent of its members stopped delivering babies because of the LI/M situation.<sup>3</sup>

Obstetricians likewise have been plagued by malpractice suits and hefty insurance premiums and are dropping OB at a significant rate. Insurance companies, on the average, increased obstetricians' annual premiums by 238 percent between 1982 and 1987.<sup>1</sup> The American College of Obstetricians and Gynecologists reported that about 12 percent of its membership ceased delivering babies in 1985

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## **The demands of OB on personal and professional life seemed to influence family medicine residents choice of practicing OB at least as much as considerations of malpractice liability and litigation.**

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and that in 1987 there was a further 12 percent withdrawal.<sup>3</sup> If present trends continue toward the end of the century, outside of teaching hospitals, will any physicians still be delivering infants?

The southeastern U.S. is said to have suffered the heaviest losses of OB services.<sup>2</sup> In Georgia, it is currently estimated that 67 of 159 counties have no physician in res-

idence who delivers babies (personal communication, Georgia Dept. of Public Health, November, 1988). Georgia is largely a rural state. Since FPs have traditionally served many smaller communities and the rural population, a study was undertaken to determine attitudes of the most recent class of family medicine resident trainees toward the inclusion of OB in their projected practices.

### **Methods**

In the late spring of 1988, a brief (one and one-half pages) questionnaire was mailed to each of the 41 resident physicians graduating from the six accredited family medicine residency training programs in Georgia. (These are located in Atlanta, Augusta, Columbus, Macon, Savannah, and Rome.) Each physician was asked to complete the questionnaire anonymously, stating whether he or she planned to include obstetrics in his/her practice and explaining negative responses. The questionnaire attempted to determine the relative importance of several suggested underlying reasons chosen not to practice OB.

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TABLE 1 — Influence of Various Reasons for Deciding Not to Include Obstetrics (OB) in Practice (N = 28)

	<i>Great influence</i>	<i>Some influence</i>	<i>Little influence</i>	<i>No influence</i>
Malpractice costs	16	3	3	0
Demands on personal life	15	5	2	0
Demands on professional life	14	6	2	0
Fear of litigation	11	8	3	0
Lack of support for doing OB in practice setting	2	8	5	7
Unpleasant obstetrician models during training	2	4	5	11
Find OB unpleasant	2	1	4	15
Inability to get OB hospital privileges	1	5	9	7
Inadequate training in residency	1	5	8	8
Lack of positive family practice role models during training	1	4	10	6
Insufficient OB patients	1	2	9	9

TABLE 2 — Respondents' Ranking of Reasons for Deciding Not to Include Obstetrics in Practice

	<i>Demands on personal life</i>	<i>Demands on professional life</i>	<i>Malpractice costs</i>	<i>Fear of litigation</i>
Number ranking item first in importance	10	1	6	2
Number ranking item second in importance	3	6	5	5

The first part of the questionnaire requested brief demographic data including the site of the training program. The second part of the questionnaire offered 11 possible reasons for not practicing OB and asked the respondent whether each reason was of great, some, little, or no influence in his/her decision. The third part of the questionnaire reiterated the 11 reasons and asked the respondent to rank them.

### Results

Of 41 questionnaires mailed, 28 were returned (68 percent). Six (21 percent) respondents planned to practice OB; 22 (79 percent) did not.

Table 1 displays the results of Part II of the questionnaire. Malpractice costs were cited as the most frequent ( $n = 16$ ) reason greatly influencing resident physicians' negative decisions. The second most frequently cited reason of great influence ( $n = 15$ ) was demands of OB on personal life. Third most frequently cited ( $n = 14$ ) was influence on one's professional life.

Eleven respondents cited fear of litigation as a great influence in a negative decision. Inability to obtain hospital privileges, inadequate training, and lack of positive family medicine teaching role models each were cited by one respondent as reasons greatly influencing decisions. The significant majority of respondents ( $n = 15$ ) stated they did not find OB unpleasant to practice. Other reasons volunteered (one respondent each) as leading to a decision against OB practice were: lack of support from obstetricians (great influence), no interest (switching to another specialty), and lack of OB services at the local hospital.

Part III of the questionnaire (Table 2) revealed 10 respondents ranking OB's demand on personal life as the number one ranking reason for a negative decision; six cited malpractice costs, and two fear of litigation as the most important reasons. Demand upon professional life was most often cited ( $n = 6$ ) as the number two reason for a negative decision; malpractice costs and fear of litigation each were cited

as the number two reason by 5 respondents. No respondent ranked inadequate training or lack of family medicine teaching role models as the first, second, or third most important reason influencing a decision. One respondent cited inability to get hospital privileges as the second most important reason.

### Discussion

The issue of LI/M is the cause most often cited for U.S. physicians deciding to forego or curtail the practice of OB. Prior to this study, the authors had hypothesized that reasons other than LI/M considerations were of significant influence in the decision of family medicine residents not to practice OB. This has been suggested by the AAFP study<sup>2</sup> (36 percent cited "other" reasons vs. 28 percent citing LI/M), and an informal rank order study conducted among graduates of the University of Connecticut Family Practice Program which showed 71 percent of respondents citing demands on personal life as a reason



for discontinuing OB versus 66 percent who cited malpractice costs as important.<sup>4</sup>

Responses to Part III of the questionnaire clearly demonstrate that demands on personal life are very important as a physician considers a service to patients that often will require a rapid (and sometimes lengthy) physician response at night and on weekends. This trend is clear from Part III even with the combined rankings of malpractice costs and fear of litigation versus personal life (6 + 2 vs. 10). Similarly, demands upon professional life (eg, being called away from an office full of patients to deliver a baby) outranked both considerations of malpractice and litigation as second in importance.

While the data of Part II are not quite congruent, with one more respondent attributing "great influence" to malpractice costs than to demands on personal life (16 vs. 15), if responses in Part II of both "great" and "some" influence are combined, more respondents cited personal life than malpractice. Similarly, if "great influence" responses of demands on personal and professional life are combined, these outnumber responses of combined malpractice and fear of litigation (29 vs. 27).

**R**edress of the malpractice nightmare of the 1980s has often focused on tort reform. Legislative tort reform relevant to medical liability thus far has been slow in coming and imperfect in execution. Furthermore, it seems necessary that judicial reform accompany legislative efforts. A recent medical liability decision by the Illinois Supreme Court generates a ray of hope that the judiciary might also finally prove responsive.<sup>5</sup>

Nevertheless, this small study suggests that influences other than considerations of LI/M were operative among Georgia family medicine residency graduates as they decided whether to practice OB. The reasoning undergirding a negative

decision is probably not so single-issue as some have suggested. As Kurtzweil<sup>1</sup> has written, a "one-size-fits-all solution" probably does not exist for the OB crisis. The data from this study suggest that merely addressing LI/M might not necessarily replenish the ranks of physicians delivering babies.

This should not be construed so as to diminish efforts at tort reform. It has been estimated that lawsuits against U.S. family physicians more than doubled between 1981 and 1984, primarily because of obstetrical claims.<sup>11</sup> Perhaps issues of demands upon personal and professional life would not weigh as heavily upon the young physician who did not dread a large insurance premium or fear being sued. The respondents in this study clearly stated that LI/M issues were important, and tort and malpractice insurance reform must be addressed as two of the influential changes necessary to entice physicians back into the delivery room.

Regarding other factors, it is significant that, as judged from our respondents, young FPs do not dislike OB. Nor do they feel they've been inadequately trained. Nor was obtaining hospital privileges to deliver babies seen as a major issue — although it might have been had there been more affirmative responders. Nor is a lack of family practice teaching role models seen as an impediment. This might be surprising in light of the fact that only about 40 percent of clinically active teaching faculty in family medicine programs in Georgia practice OB. (Personal communication, Georgia Family Medicine Residency Programs, November, 1988.)

**A** debate has been ongoing between obstetricians and FPs as to who delivers the better OB care. Two recent studies suggest that high quality OB care is delivered by FPs in a variety of settings,<sup>6,7</sup> and other studies have shown that FPs provide OB care (at least to lower risk patients) as safely

as obstetricians.<sup>8,9,12</sup> Furthermore, in a recent report from Maine, Onion and Mockapetris<sup>10</sup> have documented that in the early 1980s, FPs/GPs delivered commensurately more lower-socioeconomic (and presumed higher risk) pregnancies than their obstetrical colleagues. Thus it can be argued that a place for FPs indeed remains in the practice of OB.

In summary, this small study has suggested that among family medicine residency programs in Georgia, only about one-fifth of 1988 graduates plan to include OB in their practice. From recent data, additional attrition of this proportion over ensuing years would be expected.<sup>2,4</sup> The demands of OB on personal and professional life seemed to influence these plans at least as greatly as considerations of malpractice liability and litigation.

### Acknowledgement

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# MRI UPDATE

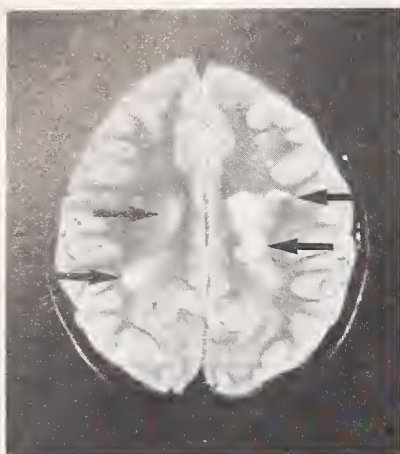


Figure 1

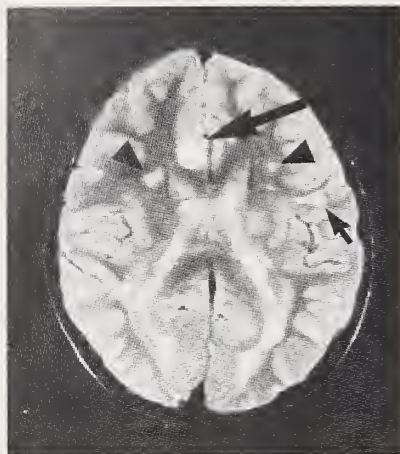


Figure 2



Figure 3

## CLINICAL INFORMATION:

Recently, there has been much discussion in the literature of the neurological symptoms caused by the spirochete *Borrelia burgdorferi*. The disease is transmitted by a tick bite and is associated with clinical symptoms of headaches, multiple arthralgias, and non-specific neurological symptoms. Given the appropriate clinical history, a diagnosis of Lyme disease can readily be confirmed by an MR scan.

**FINDINGS:** Figure 1 is a T2-weighted axial image through the brain. Abnormal focal areas of increased signal intensity can be identified within the centrum semiovale bilaterally (small arrows). These lesions are primarily located within the white matter but are of differing sizes. Figure 2 is also an axial image through the brain but at a level through the lateral ventricles. This section shows a

lesion located within the medial gray matter of the right frontal lobe anterior to the corpus callosum (large arrow). Additional areas of abnormal increased signal intensity can be identified adjacent to the occipital horns, in the gray-white matter interface of the left parietal operculum (small arrow), and in the deep white matter of the frontal lobes in the region of the anterior corona radiata (arrowheads). Figure 3 is through the posterior fossa as well as the lower frontal and temporal lobes. Abnormal areas of increased signal intensity are demonstrated in the left anterior pons (large arrow) in the anterior right temporal lobe (small arrow), in the right cerebellar peduncle (arrowhead), and in the medial right temporal lobe (curved arrow).

The MR images clearly demonstrate the predominantly white matter involvement, multifocal nature, and the absence of

mass effect associated with these lesions. In the absence of clinical history, the MR appearance would be most consistent with a demyelinating process such as multiple sclerosis. However, as this case presented in a nine year old male following exposure to ticks, the differential diagnosis becomes that of Lyme disease. The diagnosis was further confirmed by the findings of similar, although less extensive lesions, in the patient's sibling.

**COMMENT:** The patient in the case above had a CT scan prior to the MR study which was negative. This case clearly demonstrates the increased sensitivity of MR over CT in detection of white matter processes. However, the case also demonstrates the relative non-specificity of the findings. In this case, the clinical history was most important in determining the true etiology of the patient's findings.



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## *Safeguarding Your Medical License After Retirement*

Deborah M. Bittel

**“By placing your medical license on an “inactive” status when you retire, you can avoid any administrative revocation of your license and simplify the reactivation of that license.”**

“**D**R. J” HAS BEEN RETIRED now for approximately 6 months. When he retired, like many other doctors, he simply allowed his medical license to lapse by virtue of not paying his bi-annual registration fee. Now he is facing the revocation of that license in accordance with the statutes governing medical licenses. Although the procedure is purely administrative and the record does not indicate any disciplinary action, the end result is a “revocation” of his license. Moreover, “Dr. J” has become involved in his son’s little league team and wants to provide medical assistance to his son’s injured friends. However, with the revocation of his license he cannot participate in any type of medical practice. Although he does not wish to participate in an active practice, even furnishing medical coverage briefly for a

summer camp or some charitable organization is prevented due to the revocation of his license. Furthermore, the complicated process for restoring his license has made “Dr. J” reconsider getting involved in a non-active medical practice.

This hypothetical situation raises the question concerning what a physician, such as “Dr. J,” at the time of retirement, can do to prevent the revocation of his license and still participate in some way without entering active practice. The simple answer is that “Dr. J” could have requested that his license be placed on an “inactive” status, thereby avoiding any administrative revocation of his license and simplifying the prospect of reactivating that license.

In this month’s Legal Page, we provide an overview of the current Georgia statutory provisions governing the revocation of a medical license; we also discuss the difference between the revocation of a license and placing it on inactive status.

### **Overview of Statutory Framework**

Chapter 43-34 of the Georgia Code (the “Statute”) governs the

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practice of medicine in the State of Georgia; Section 43-34-37 of the Statute provides a laundry list of instances where the Composite State Board of Medical Examiners (the “Board”) is granted the authority to issue a license to an applicant or to discipline a licensed physician. For example, the Board may discipline or refuse to grant a license to a physician upon a finding that the physician has failed to demonstrate the qualifications or standards for licensure contained in the Statute or in the rules and regulations of the Board.<sup>1</sup> The Board may also discipline or refuse to grant a license to a physician if that physician knowingly made misleading, deceptive, untrue, and fraudulent representations in the practice of medicine or in any document connected with that practice; fraudulently obtained a license to practice medicine; made a false or deceptive bi-annual registration with the Board; was convicted of a felony; or committed a crime involving moral turpitude without regard to conviction.<sup>2</sup>

Other things physicians may do which could give rise to a Board revocation proceeding include: advertising for or soliciting patients;<sup>3</sup> making untruthful, improbable, flamboyant, or extravagant claims concerning their professional excellence; engaging in any unprofessional,<sup>4</sup> unethical or deceptive conduct or

practice harmful to the public, which may or may not necessarily result in actual injury to any person; performing, procuring or aiding in the performance or procuring of a criminal abortion; or knowingly maintaining a professional connection or association with any person who is in violation of the Statute or the rules or regulations of the Board. Additionally, a revocation proceeding may be initiated if a physician violated or attempted to violate a law, rule, or regulation of the State of Georgia, any other state, the Board, the United States, or any other lawful authority (without regard to whether the violation is criminally punishable as long as that law relates to or in part regulates the practice of medicine), committed any act or admission which is indicative of bad moral character or untrustworthiness, has been adjudged mentally incompetent by a court of competent jurisdiction, has become unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.<sup>5</sup>

Perhaps most importantly, the Board has the authority to discipline or refuse to grant a license to a physician if that licensee or applicant has had his license to practice medicine revoked, suspended, or annulled by any lawful licensing authority, or had other disciplinary action taken against him by any lawful licensing authority, or was denied a license by any lawful licensing authority.<sup>6</sup>

When the Board finds that any person does not qualify for a license or finds that any person should be disciplined pursuant to the Statute, the Board can take

one or more of a number of possible actions: Refuse to grant a license to an applicant or revoke the license of a physician, administer a public or private reprimand, suspend any license for a definite period, or limit or restrict any license. The Board also has the authority to condition the penalty, or withhold formal disposition, upon the physician's submission to and completion of the care, counselling, or treatment of a physician or other professional persons as directed by the Board. In addition to the previous actions, the Board may make a finding adverse to the licensee or applicant but withhold imposition of judgment and penalty, or it may impose a judgment or penalty but suspend enforcement of that judgment and place the physician on probation. Moreover, in its discretion, the Board may restore and reissue a license to practice medicine issued under the Statute and, as a condition of the restoration, may impose any disciplinary or corrective measure as provided in the Statute.<sup>7</sup>

The basic policy behind the Statute was enunciated in *Geiger v. Jenkins*,<sup>8</sup> where the court found that the right to practice medicine is a conditional right which is subordinate to the State's power and duty to safeguard the public health. Thus, it is the universal rule that in the performance of that duty and in the exercise of that power, the State may regulate and control the practice of medicine and those who engage in that practice, subject only to the limitation that the measures adopted must be reasonable, necessary, and appropriate to accomplish the legislature's valid objective of protecting the health and welfare of its citizens. The Statute has survived numerous

constitutional challenges. For example, in *Jackson v. Composite State Board of Medical Examiners*,<sup>9</sup> the court found that the Statute was not unconstitutionally vague and that there was no denial of equal protection or violation of a physician's due process rights with respect to the rules and regulations necessarily adopted by the Board to effectuate the already mentioned policies.

**‘Following the expiration of the penalty period, the Board may revoke the license for failure to renew, and such revocation removes all rights and privileges to practice medicine and surgery in the State.’**

#### To Revoke or Not Revoke

Under Section 360-2-.07 of the *Rules of the Composite State Board of Medical Examiners*, the procedures to revoke or place a license on inactive status are more fully discussed. That Section provides that unrestricted medical licenses must be renewed bi-annually. If not renewed bi-annually, the Statute provides for a penalty period for late renewal. This period is the 6-month period immediately following the expiration date for the last renewal cycle. During this period, the penalty fee for late renewal applies. Following the expiration of the penalty period, the Board may revoke the license for failure



to renew,<sup>10</sup> and such revocation removes all rights and privileges to practice medicine and surgery in this State.

**A**ny practitioner whose license is revoked through this method must apply for licensure to be considered for reinstatement. Revocation for failure to renew may be reported to the public and to other State licensing boards, and will be reported as a revocation for failure to renew and will not be treated as a disciplinary action revocation.<sup>11</sup> Nevertheless, this Section points out two unattractive elements of the revocation procedure. The first is that after a revocation, if a physician desires to be reinstated, he must apply for licensure, as if he was never licensed in the first place. This means that changed circumstances, such as any malpractice actions, even favorably resolved ones, can reduce the likelihood of the issuance of a new license. The second unattractive aspect is that this failure to renew will be reported as a revocation, which, although not due to a disciplinary action, connotes a negative impression. Although it may be reported to the public and other State licensing boards as a revocation for failure to renew, the use of the word "revocation" implies an involuntary confiscation of the license, rather than a mere retirement.

However, the Regulations also provide that licensees who wish to maintain their medical licenses, but who do not wish to practice medicine and surgery in the State, may apply to the Board for inactive status by submitting

an application and fee. Although a licensee with an inactive license may not practice medicine in this State, an inactive license may be easily restored. A license that has been placed on inactive status may be reactivated, subject to Board approval and upon payment of the reinstatement fee and submission of an application as required by the Board. Furthermore, physicians

***‘The Regulations provide that licensees who wish to maintain their medical licenses, but who do not wish to practice medicine and surgery in the State, may apply to the Board for inactive status by submitting an application and fee.’***

requesting reinstatement must be able to demonstrate to the satisfaction of the Board that they have maintained current knowledge, skill, and proficiency in the practice of medicine. Although the Board may require the physicians to pass an examination, the procedure to reinstate a physician of inactive status is simpler to comply with than the application for licensure which is necessary to reinstate a revocation.<sup>12</sup>

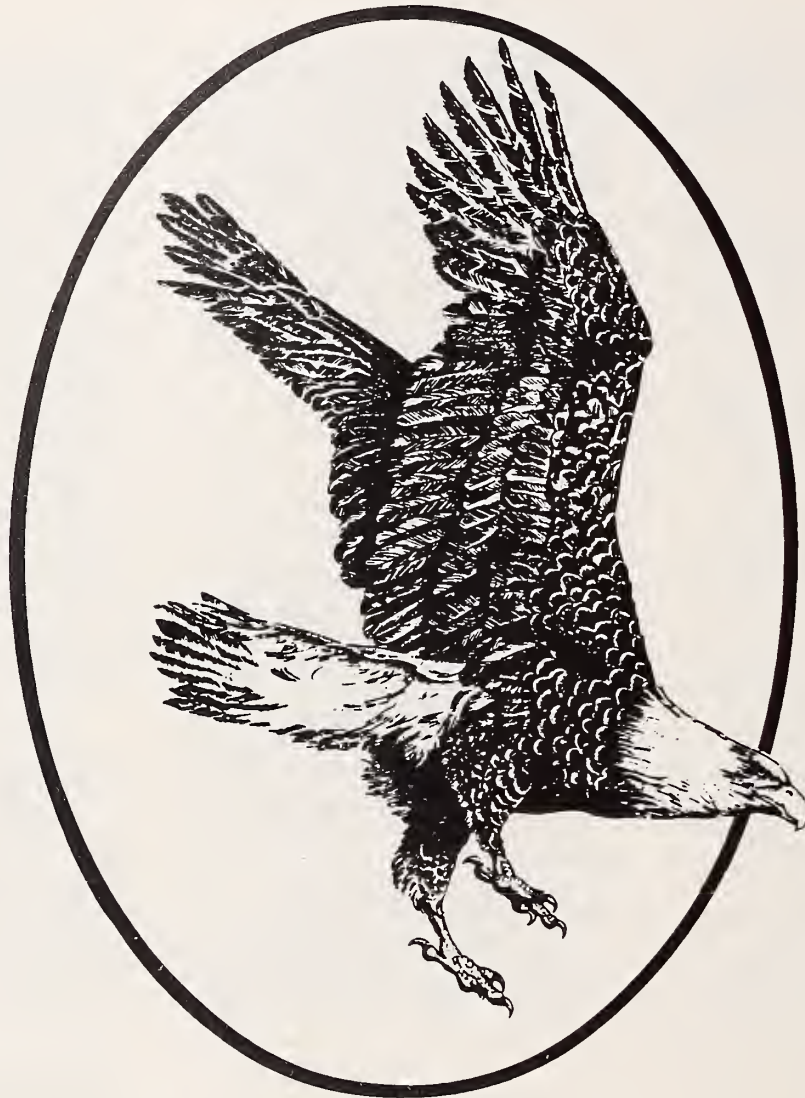
#### Conclusion

Assuming, in our hypothetical case, that "Dr. J" did not desire to

irrevocably stop practicing medicine, the better path for him to take would be to have his license placed on inactive status, rather than allowing the license to lapse through failure to renew, thereby instigating the possibility of a revocation. If "Dr. J's" license had been placed on inactive status, his license could have easily been reactivated in order to allow him to provide the charitable services that he desires. However, in order to have his license reactivated from a revocation for failure to renew, he must instead apply for licensure and depend on the Board's discretion to restore and reissue a license to practice medicine.

#### Notes

1. Rules and Regulations of the State of Georgia §360-2-.07.
2. O.C.G.A. § 43-34-37.
3. This aspect of the Statute appears to be in conflict with the law of Georgia over the past fifteen years addressing physician advertising. Although the Statute still provides for discretionary discipline when a physician advertises, current case law suggests that principles which prohibit professional advertising are unconstitutional. See *Virginia Pharmacy Board v. Virginia Consumer Council*, 425 U.S. 748 (1976); *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977).
4. O.C.G.A. § 43-34-37. The term unprofessional conduct as used in the Statute includes any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice. The term also involves, but is not limited to, the prescribing or use of drugs, treatment or diagnostic procedures which are detrimental to the patient. See Rules and Regulations of the State of Georgia § 360-2-.09.
5. *Id.*
6. *Id.*
7. *Id.*
8. 316 F. Supp. 370 (N.D. Ga. 1970), *aff'd.*, 401 U.S. 985, 91 S. Ct. 1236 (1977).
9. 256 Ga. 264, 347 S.E.2d 581 (1986).
10. In *Smith v. State Board of Medical Examiners*, 40 Ga. App. 456, 167 S.E. 769 (1933), the court held this provision was not mandatory due to the use of the word "may." Rather, the revocation of the physician's license is within the Board's discretion.
11. Rules and Regulations of the State of Georgia § 360-2-.07.
12. *Id.*



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## Management of Pain in Patients with Malignancy

Steven F. Brena, M.D., Steven H. Sanders, Ph.D.

### Introduction

**E**STIMATES OF THE PREVALENCE of pain associated with malignancy range from 60-82%.<sup>1</sup> During 1981-1982, a survey of 120 patients referred to the UCLA Cancer Pain Clinic indicated that pain secondary to tumor invasion occurred in 61.7% of patients. Bone metastasis was the most common (18.3%), followed by neural invasion (15.8%) and viscera invasion (10%). Almost one-third of the patients in the UCLA survey had pain secondary to oncologic therapy for cancer control and not due to tumor invasion.<sup>2</sup>

Despite the prevalence of pain in cancer patients, not enough attention has been given to structured pain control programs for cancer patients. With the exception of a few highly sophisticated cancer pain control centers, the overwhelming majority of cancer patients are still treated with an acute medical model, mostly with prescriptions of various drugs, many of them habit-forming, leading to physical dependence and tolerance. Even less attention is paid to the possibility for rehabilitation for non-terminal cancer patients, despite the fact that research data have indicated that over 40% of patients with cancer in all sites do have a physical and psychologic impairment which can be significantly improved

***‘This article provides a brief overview of the physical and psychologic factors associated with cancer pain and outlines current pain rehabilitation management strategies which have demonstrated utility with a structured, long-range treatment approach.’***

through rehabilitation medicine.<sup>3</sup> This article provides a brief overview of the physical and psychologic factors associated with pain in adult cancer patients and outlines current pain

rehabilitation management strategies which have demonstrated utility within a structured, long-range treatment approach.

### Common Physical Factors in Cancer Pain

*Tissue invasion from malignant growth.*

Any tissue of the body is likely to cause pain whenever the growth involves nerve structures, peripheral vessels, or both. By far the most common cause of cancer pain is destruction of bone with neurologic complication from metastatic disease.

*Painful syndromes caused by medical intervention.*

The common denominator for pain following cancer therapy is nerve damage and circulatory disturbances from damage to peripheral vessels. Both irradiation therapy and extensive destructive surgery, such as radical nerve dissection, often result in extensive fibrosis of the connective tissue, with secondary entrapment of peripheral nerves and vascular structures. Surgical amputation of a limb may result in pain in the stump or in phantom limb pain. Various neuralgias may develop following surgical procedure which has caused a peripheral nerve damage, mostly when a thoractomy has been performed. Post-chemotherapy pain is caused by several lesions, which include

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peripheral neuropathy, bony necrosis, and herpetic infection. Mostly in elderly people, the herpetic infection may result in painful post-herpetic neuralgia.<sup>4</sup>

### **Psychologic Factors in Cancer Pain**

*Behavioral and interpersonal deterioration.*

General reduction in activity levels, loss of ability to maintain activities of daily living, and reductions in interpersonal and social stimulation have been found to significantly exacerbate the patient's level of pain and distress.<sup>5,6</sup> The end result is decreased emotional and physical resistance to the stresses of both cancer growth and cancer therapy, as well as more time and opportunity to focus on the painful experience.<sup>7,8</sup>

#### *Stress.*

The exacerbatory effects of stress on clinical pain have long been appreciated and empirically demonstrated.<sup>9</sup> The host of potential physical and psychosocial stressors for the cancer patient is likely to significantly contribute to the pain experience, with a tendency to escalate in magnitude as the disease progresses. Even with remission, there can be an ongoing residual level of stress associated with the fear of disease return and death.

#### *Mood disturbances.*

Anxiety, anger and depression all have demonstrable exacerbatory effects on clinical pain.<sup>9,10</sup> These mood disturbances are quite common with cancer patients and further add to the pain experience. Actually, specific mood disturbances are embedded in a more general grief reaction experienced in one form or another by the cancer patient

throughout the course of his or her illness.<sup>11</sup>

### **Management Strategies for Pain Control in Cancer Patients**

Because the experience of pain is a multi-dimensional physiologic and psychosocial phenomenon, the basic philosophy of pain control programs is that proper management of pain, mostly in its chronic form, should identify, address, and possibly correct all physical, behavioral, and psychosocial malfunctions associated with each person in pain. Specifically, for the cancer patient, this multi-dimensional strategy should be diversified in three stages of intervention.

#### *Stage 1*

During the earlier stages of malignancy, along with appropriate oncologic treatment of the malignancy itself, attempts should be made to minimize the responses of patients to early painful perceptions and to avoid the formation of multiple vicious cycles of pain and suffering. These goals can be accomplished through information and communication, as well as with the skillful use of psychologic-behavioral treatment. In general, the interventions should be focused on minimizing those psychologic factors which have already been mentioned (i.e., loss of activity, loss of social stimulation, increase of stress, and mood disturbances). The ultimate goal is to significantly improve the patient's ability to effectively cope with the pain and distress associated with both the disease itself and the oncologic treatment. Techniques which have been proven useful to achieve these goals include: relaxation therapy, biofeedback treatment, self-hypnosis, and cognitive and behavioral activity

***‘The ultimate goal is to significantly improve the patient's ability to effectively cope with the pain and distress associated with both the disease itself and the oncologic treatment.’***

management.<sup>8,12</sup> Group therapy may also be useful to effectively address stress within and outside the family, by providing effective modeling of adaptive thinking and behavior for patients and family members.

#### *Stage 2*

Tumor-directed therapy may result in pain reduction by reducing the size of the tumor. However, during the more advanced stages of the disease, further diminution of the tumor is no longer feasible through oncologic treatment. At this stage, pain becomes a disease entity in itself, and further modalities must be aimed at managing it as a disease.

#### *A. Analgesic drug management.*

Proper analgesic drug therapy should be carefully tailored to each individual, with careful consideration of the nociceptive, levels of physical and psychosocial dysfunction, and the pharmacodynamics of the prescribed drugs. Analgesics, such as acetaminophen, aspirin, and the non-steroidal anti-inflammatory drugs (NSAIDs) are probably the drugs of first choice in Stage 2 cancer patients with currently acute episodes of pain. Both aspirin and acetaminophen are equally effective at 650 mg.



dosage, with a ceiling effect of around 600-900 mg. Above this dosage, peak effectiveness increases slightly, but side effects and toxic reactions become likely. Equipotent doses of NSAIDs have a greater peak effect and longer duration than aspirin. All peripheral analgesic drugs, with differing degrees, demonstrate similar side effects on various body systems.

Central analgesics (opiates and opioids) should be reserved to those more advanced cases of cancer pain, when the reported pain intensity is more severe. When central analgesic drugs are used, the following points should be considered:

(1) regularly scheduled drug administration on a time contingency is far better than PRN administration. Allowing for variations in potency, efficacy, and duration of action of the central analgesic drugs, a regular dosage schedule minimizes peaks and valleys in pain intensity.

(2) The oral route of opiates has a lower onset of action than the IM or IV routes, but a longer duration of analgesia protection.

(3) Tolerance develops in all patients who take central analgesics habitually, the earliest sign being decreased duration of analgesia. Tolerance develops at different speeds according to the route of administration: the IV route produces tolerance more quickly than the IM and oral routes, respectively; since cross-tolerance among opiates is not complete, analgesic protection may be achieved by switching a patient from a large dose of one opiate to a smaller dosage of another.

(4) Tricyclic antidepressants should be considered as potentially useful in managing pain in Stage 2. Recent evidence

has indicated that these drugs may actually have a specific effect on certain serotonergic pain pathways within the central nervous system, possibly by interacting with opiate receptors directly to produce analgesia and indirectly to increase morphine analgesia.<sup>13</sup> Among the many tricyclic antidepressant drugs, when analgesic effect is the primary pharmacologic target, preference should be given to those drugs, such as Doxepin and Amitriptyline, with higher affinities for serotonin receptors.

Unfortunately, Doxepin also demonstrates the highest affinity for histamine receptors, leading to clinical drowsiness. On the other side, Amitriptyline has less histamine affinity; for this reason, Amitriptyline is probably the tricyclic antidepressant of choice whenever such medication is prescribed primarily for analgesia, which can be achieved long before the dosage reaches antidepressant levels.

**‘Among the many tricyclic antidepressant drugs, preference should be given to those drugs with higher affinities for serotonin receptors.’**

*B. Neural blockade.* Drug management for cancer pain can be usefully supplemented by neural blockage of nociceptor pathways. In cancer patients, attempts have been made to prolong the duration of nerve blocks (limited to 8-12 hours when a local anesthetic agent is

**‘At present, sympathetic nerve blocks, celiac plexus blocks, and epidural blocks are useful techniques of neural blockade to temporarily control cancer pain.’**

used) by injecting a neurolytic agent, such as alcohol or phenol, which causes destruction of nerve structures. Early literature on pain is full of descriptive reports extolling the great usefulness of nerve blocks in controlling all pain syndromes, including cancer pain.<sup>14</sup> However, the majority of these reports have not withstood the test of controlled research and have somewhat fallen out of use. More so, the use of many neurolytic nerve blocks has been discontinued, as the painful consequences of nerve damage and subsequent denervation syndromes have been recognized. At present, sympathetic nerve blocks, celiac plexus blocks, and epidural blocks have been able to pass the test of time and clinical experience as useful techniques of neural blockade to temporarily control cancer pain, either by using anesthetic solutions or — in selective cases — neurolytic solutions.<sup>15, 16</sup>

*C. Psychologic-behavioral treatment.* Finally, upon entering Stage 2 of the disease process, the potential usefulness of psychologic-behavioral treatment to reduce the pain and distress experience becomes even more significant. In general, psychologic-behavioral treatment during Stage 2 involves



continuation of those techniques already employed during Stage 1, in concert with increase in more aggressive pharmacologic pain control at the systemic and regional levels. Particular emphasis should be given to titration of patients' behavioral activity schedule in keeping with the need to maximize activity levels and the reality that analgesic interventions result in some reduction in behavior and loss of function. A marked focus on increasing pleasurable activities on a daily basis and on maintaining self-control and ability to manage pain and distress effectively is quite important to offset the escalation typically observed in mood disturbances during Stage 2. Also, as Stage 2 progresses, attention should be more directly given to potential death and dying issues inherent in such progression.

### *Stage 3*

The terminal phase of cancer disease is reached when a patient's life expectancy is no greater than a few months. At this stage, usually the oncologic treatment is discontinued, while all the supportive and analgesic modalities already in use during Stage 2 must be reassessed and readjusted. Routes and choices for analgesic drug therapy must be adapted to the needs of Stage 3 terminal patients, given proper consideration to nociceptive mechanisms and psychologic factors. If nausea and vomiting become prominent, certain opiates, such as Numorphan and morphine, are available for rectal usage and may be quite useful in patients with gastrointestinal obstructions, limited venous access, and reduced muscular mass. IM and IV routes may be considered, keeping in mind that such routes inevitably accelerate

the drug tolerance and physical dependence processes. Aspirin, NSAIDs, and Hydroxyzine HCl have been shown to significantly potentiate the analgesic effects of opiates and opioids. For example, in a double-blind, crossover study, Breckner and Gantz have demonstrated that the combination of ibuprofen with methadone significantly increased the analgesic potency of the same dose of methadone, mostly in patients with bone metastases.<sup>17</sup> Brompton's mixtures are popular for pain control in terminal cancer patients; however, a double-blind comparison of morphine solution vs. morphine in the Brompton's mixture has shown no difference in analgesic potency and side effects.<sup>18</sup> Continuous epidural infusions of an anesthetic agent may be useful in patients with severe metastatic pain in the lower spine and limbs. The main advantage is that the resultant analgesia is not cross-tolerant with central analgesic drugs, thus allowing some reduction in dosages of opiate medication.

In the unfortunate case where conservative drug therapy and block therapy are not longer effective and the painful experience is not controlled by the patient's capability of managing himself or herself, several neural-ablative surgical procedures are presently available. All of them result in destruction of nerve fibers and structures and have clinical indication only in patients with short life expectancy, before painful complications from iatrogenic nerve damage can develop. Cordotomy remains the most useful and well documented approach. New surgical techniques include radio frequency lesions in the dorsal

horn of the spinal cord, hypophysectomy, and implants of various electrical devices for stimulation of certain pain-suppressive areas of the central nervous system.

During the end stage of cancer disease, psychologic-behavioral strategies should be focused on helping the patient and family to intellectually and emotionally reconcile the inevitability of death and the quality of living for the terminal patient. Behavioral activity management should center around stabilization of routine and assisting the patient in taking care of those activities in preparation for death. Such management can significantly reduce stress and mood disturbances which exacerbate the general level of suffering. Increased attention to the grief process of family members through individual and group intervention may be necessary and useful to offset suffering in patients, who are quite often very concerned and distressed about family grief.

### **Closing Remarks**

With cancer patients, control of neuroplastic growth should be matched by equally vital control of pain, so that the patient's overall physical, emotional, and social functioning is protected as much as possible. Every effort should be made to maintain the patient's capability to endure and to cope. There is greater need for more of an integrated approach to *total* patient management strategies. Without it, cancer patients often experience emotional and social "death" long before the biologic end occurs. For many cancer patients, an integrated management approach can best be accomplished through interdisciplinary, goal-



oriented health care, such as that offered in accredited, quality pain control rehabilitation facilities in the United States.

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# VASOTEC®

## (ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

**Contraindications:** VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions:** **General:** **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Osmotic reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients:

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

#### Drug Interactions:

**Hypotension:** **Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucuronides, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, furosemide, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (30 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of <sup>14</sup>C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**HYPERTENSION:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**HEART FAILURE:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation, palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

#### Clinical Laboratory Test Findings:

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration:** **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >16 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19386. J6VS18R2(817)

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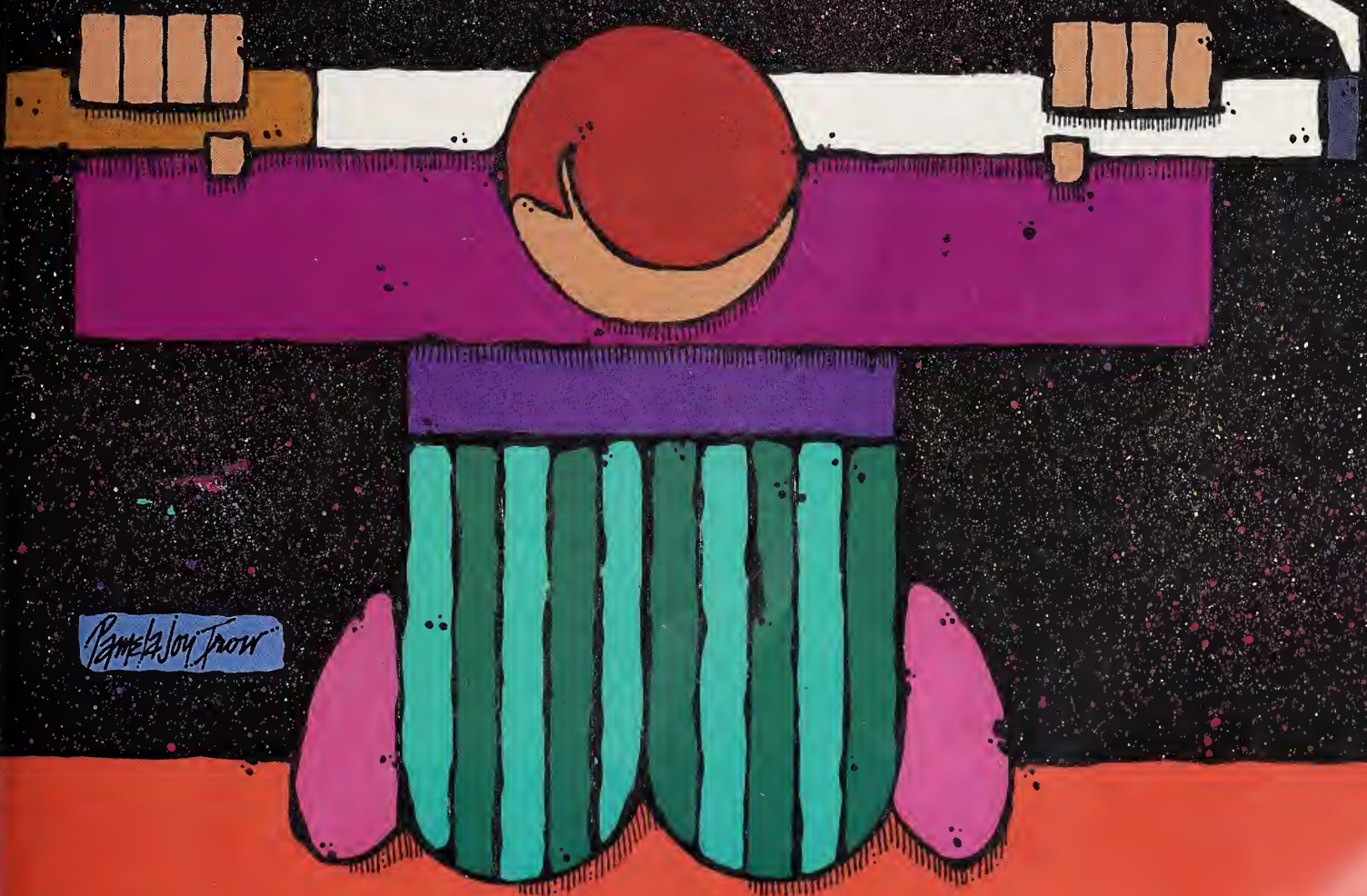


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**THE COVER**

Our cover art this month depicts the deadly burden of smoking as reported in the article by Dr. Steven Wassilak, et al. on p. 601 and the editorial by Dr. Sheldon Cohen on p. 593.  
Artwork by Pamela Trow, 428 Page Ave., Atlanta, GA 30308; 404-378-7450. Original art (image area 12½" × 17") available for purchase. Contact Ms. Trow.



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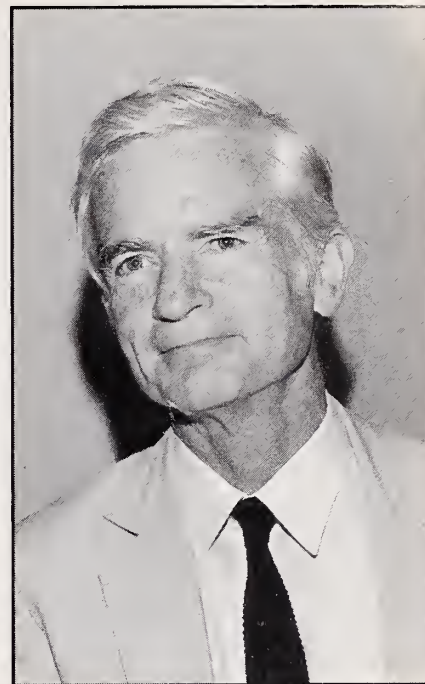


## *Our Auxiliary Allies*

**R**ECENTLY, a congressional subcommittee was scheduled to vote on an issue that may dramatically change the practice of medicine in the United States — Expenditure Targets. An undecided congressman on the subcommittee was considered to be the swing vote. The AMA asked us to activate our Phone Bank and even sent down observers from Chicago to check on its effectiveness. Our MAG Auxiliary immediately went into action, and Congressman Ed Jenkins was deluged with effective telephone calls pointing out that expenditure targets would be the first step toward rationing medical care in the United States. Although he voted for us, the committee as a whole voted expenditure targets out of Subcommittee, and the fight goes on.

This is just one example of the effectiveness of our Auxiliary, probably medicine's best advocate.

Last night my wife, in her capacity as Auxiliary Resident Spouse Liaison Chairman, entertained a group of thirty resident wives at our home with a Low-country Boil. I was supposed



*Joe L. Nettles, M.D.*

to do the cooking but could not get out of the operating room in time — but as usual, things went well anyway.

Last week I attended the Summer Board Meeting of the MAG Auxiliary at Pine Isle. I heard Immediate Past President Jan Collins report on the myriad activities of the past year, including the adolescent health program, the Healthy Lifestyles campaign, and the marvelous, "It's Up To Youth" Teen Health Forum. I then watched Grace Walden lead the planning for this year's Auxiliary activities — a truly ambitious undertaking.

**I**n Georgia, we have 2,400 spouses who are ordained as our Auxiliary; nationwide we have 80,000.

Just as I was too busy in the operating room, the physicians of the country may not always have the necessary time to devote to needed activities, but our auxiliary can be depended on to assist us in our effort to take care of the patients of this nation.

We thank you, Auxilians.

## NEW MEMBERS

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Burton, Norris R., Family Practice — Ben Hill-Irwin — (Active N2) P.O. Box 929, Apollo Dr., Fitzgerald 31750

Cabral, Justo F., Family Practice — South Georgia — (Active) 103 Woodrow Wilson Dr., Valdosta 31602

Copeland, Jack L., Internal Medicine — Colquitt — (Active) #9 Hospital Pk., Moultrie 31768

Cowles, Robert S., Urology — Crawford W. Long — (Active) 1010 Prince Ave., Athens 30606

Cox, Brian G., Nephrology/Internal Medicine — Richmond — (Active) 1009 Medical Center Dr., Augusta 30907

Farman, Douglas P., Pulmonary Diseases — Richmond — (Active) 820 St. Sebastian Way, Ste. 2-B, Augusta 30902

Freedman, Allan, Hematology/Oncology — DeKalb — (Active) 2151 Fountain Dr., Ste. 304, Snellville 30278

Gulley, Sharon G., Gynecology — MAA — (Active) 3193 Howell Mill Rd., Ste. 317, Atlanta 30327

Gussack, Gerald S. Otolaryngology — MAA — (Active) 1365 Clifton Rd., N.W., Atlanta 30322

Hall, Vaughan D., Family Practice — Elbert — (Active N2) 33 Chestnut St., Elberton 30635

Howell, Elizabeth F. Psychiatry — MAA — (Active) 1365 Clifton Rd., N.E., Atlanta 30322

Johnson, Alice O., Internal Medicine/Gastroenterology — MAA — (Service) 1593 Mason Mill Rd., N.E., Atlanta 30329

Kegel, Jennifer L. — MAA — (Student) 1529 Farnell Court, Apt. 1, Decatur 30033

Laverson, Steve, General Surgery — Bibb — (Resident) 777 Hemlock St., Hospital Box 140, Macon 31208

Lawson, David H., Medical Oncology — MAA — (Active) 1327 Clifton Rd., N.E., Atlanta 30322

Lynch, Mary G., Ophthalmology — MAA — (Active) 1327 Clifton Rd., N.E., Atlanta 30322

Major, Grant R., General Surgery — Troup — (Active N2) 303

Smith St., La Grange 30240

Marchetti, Anthony J., Critical Care & Internal Medicine — Richmond — (Active) 1220 George C. Wilson Dr., P.O. Box 3726, Augusta 30912-3726

Patrick, Laura E., Pediatric Radiology — MAA — (Active N2) 1405 Clifton Rd., N.E., Atlanta 30322

Phillips, Keith M., Allergy & Immunology/Pediatrics — MAA — (Active) 2063 Deborah Dr., N.E., Atlanta 30345

Rowley, F. Lawrence, Psychiatry — MAA — (Service) 878



*At the June meeting of the American Medical Association in Chicago, Alan Nelson, M.D., President-Elect of the AMA, addresses issues in Reference Committee F. Ellis B. Keener, a neurosurgeon from Gainesville, waits his turn to speak.*



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J. Dewey Gray Cir., Augusta  
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Talley, Roy L., Anesthesiology —  
DeKalb — (Active) 755  
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Thrower, Harvey Carlton,  
Diagnostic Radiology —  
Spalding — (Active) P.O. Box  
965, Griffin 30224

Weaver, David R. General Surgery  
— Muscogee — (Resident) P.O.  
Box 951, Columbus 31994-2299

Wolpert, James J., Pediatric  
Urology — MAA — (Active N2)  
1901 Century Blvd., N.E., Ste.  
14, Atlanta 30345

## PERSONALS

*Bibb CMS*

**Milford B. Hatcher, M.D.**, a surgeon from Macon, received the honorary Doctor of Science degree at the fourth commencement exercises of the Mercer University School of Medicine (MUSM) last June.

The Emeritus Chairman of the Department of Surgery and a professor at MUSM, Dr. Hatcher began practicing general surgery in Macon in 1939. From April, 1982, to July 1, 1986, he headed the department of surgery at MUSM where he supervised a volunteer staff of 50 surgeons trained in all surgical specialties.

While on the MUSM faculty, Dr. Hatcher was named "Physician's Physician" and received the Ath-



*Dr. Jeff Nugent (R) receives the Arthritis Foundation's National Volunteer Service award from Larry Daniel, Southeastern area VP.*



*Shown here is the AMA's Young Physician Section Governing Council (L to R): Neil Winston, Member-at-large; S. William Clark, III, Delegate; George E. McGee, Immediate Past Chairperson; Leslie R. Capin, Alternate Delegate; Richard M. Lauve, Chairperson; Robert M. Bogin, Chairperson-Elect; and Martin Guerrero, Member-at-large.*



eroinatous Award for "outstanding contribution to the school." He has been named "Alumnus of the Year" at the Medical College of Georgia. He has held numerous positions of leadership both in medical affairs and in many other diverse organizations, including the presidency of the Medical Association of Georgia.

**Beverly B. Sanders, M.D.**, a dermatologist from Warner Robins, was named a member of the state Workers Compensation Medical Board by Gov. Joe Frank Harris.

## *Medical Association of Atlanta.*

**Jeffrey T. Nugent, M.D.**, an orthopedist in Atlanta, recently received the Arthritis Foundation's National Volunteer Service Award.

Dr. Nugent is a member of the Board of Directors of the Arthritis Foundation, Georgia Chapter. He currently serves as Chairman of the Chapter's Patient Services Committee and, in 1987, he served as Co-Chairman of the Foundation's Crystal Ball, along with his wife, Dr. Elizabeth Nugent.

## *Whitfield-Murray CMS*

Dalton ophthalmologist **William L. Barnwell, M.D.**, was elected president of the Georgia Society of Ophthalmology.

Dr. Barnwell is a member of the medical advisory board of The Georgia Society To Prevent Blindness, the Board of Directors of The Oscar Jonas Foundation; vice president of the medical staff of Hamilton Medical Center; and a Fellow of The American Academy of Ophthalmology. He is also secretary of the Seventh District Medical Society.



*Seated left to right: Dr. John Anatalis, vice president, Whitfield-Murray County Medical Society; Dr. William Blackman, secretary-treasurer; Mrs. Polly Talbott, Dr. Doug Talbott; Janet Lull, Whitfield-Murray County Auxiliary. Standing: Dr. Robert A. Burns, CMS president.*

## SOCIETIES

As one of 60 county medical societies in Georgia, the **Whitfield-Murray County Medical Society** (the "Society") is one of the most active, with over 90 members representing almost all the physicians in the community. This Society has been especially busy under the leadership of its president, Dr. Robert Burns, a general surgeon from Dalton. A description submitted by Dr. Burns of some of the topics of their monthly meetings follows.

In January, Dr. William C. Collins, at that time a candidate for President-Elect of the MAG, spoke to the Society about legislative activities. Drs. John Antalis, William McDaniel, Wally Weeks, and Burns subsequently participated in the MAG Physicians Involvement Program

during the 1989 Georgia General Assembly. Dr. Bates Bailey served as Doctor of the Day at the Capitol while the legislature was in Session.

Dr. Bob Bowers presented a program on contract medicine in February. As past president of the Hamilton County Medical Society in Chattanooga, Dr. Bowers helped initiate a program that actively reviews contracts for physicians. He demonstrated that most contracts have serious problems and that almost all contracts are negotiable.

In March, the Society's auxiliary sponsored a program on the medical marriage. Dr. Doug Talbott was the featured speaker for what was an interesting and stimulating meeting.

The April and May meetings were devoted to developing a public Statement on AIDS. This



# Statement Of The Whitfield - Murray County Medical Society

AIDS and the transmission of the AIDS virus is a real concern of every individual in our community. Information about this disease is easily misunderstood. In an effort to assist in educating the public and in order to allay community members' fears about AIDS, we, the physicians of the Whitfield-Murray County Medical Society, wish to share the following information.

AIDS cannot be transmitted through casual contact such as touching or hugging, or even by sharing the household with an infected person. AIDS is caused by a blood-borne virus and cannot be transmitted through the air, water, or sewage. Community members, friends, family members, and medical personnel are not at an increased risk for contracting AIDS from contact with AIDS patients in the context of routine daily care. Only by engaging in risk behaviors with persons infected with the AIDS virus is there a danger of catching the HIV infection.

In the medical setting, standard protective precautions should always be taken when there is direct contact with a person's blood or body fluids.

AIDS is a communicable disease which is transmitted by direct contact with contaminated body fluids in one of four ways:

1. The AIDS virus (HIV) is transmitted sexually by either heterosexual or more commonly (in the United States) homosexual activity.
2. I.V. drug users transmit the AIDS virus (HIV) when infected blood from one user is injected into the blood stream of another user when contaminated needles are shared.
3. The AIDS virus (HIV) may be transmitted across the placenta from the blood stream of infected mothers to their unborn infants.
4. The AIDS virus (HIV) can be transmitted through contaminated blood products. This most commonly occurred from blood transfusions received before March 1985, when the routine testing of blood and blood products for the AIDS virus had not yet been established.

Furthermore we, the physicians of the Whitfield-Murray County Medical Society, support and encourage all persons who provide care for the terminally ill in our community, including those terminally ill patients with AIDS. We recognize the need for and we support the concept of a local home or shelter for those terminally ill patients who are unable to receive care in their own homes. This allows for quality medical care for those patients and reduces the tremendous cost to the community. Such an arrangement for AIDS patients should not put any members of the community at risk for contracting AIDS.

We have the assurance from Hamilton Medical Center Hospice that the patients referred to such a shelter by HMC Hospice will meet the following criteria for admission:

1. The referred patient must be:
  - a. Terminally ill.
  - b. Referred by a licensed physician from the local area.
  - c. Approved for admission to HMC Hospice by the Hospice Medical Director.
  - d. Receiving medical care supervised by his local referring physician.
  - e. Residing in the three-county area covered by HMC Hospice (Whitfield, Murray, and Gordon counties.)
2. The referred patient will have been determined by HMC Hospice to be homeless, or have no other acceptable means of receiving proper care in his home.
3. It is recognized that some referred patients will have AIDS (Acquired Immune Deficiency Syndrome).

AIDS is of great concern to the physicians of the Whitfield-Murray County Medical Society. We anticipate that it will become a greater problem for our community in the future. We request of the general public a response of calm and tolerance toward this problem. And we ask that people show concern, caring, and kindness for those so unfortunate as to have this disease.

We also want to inform the public that the Whitfield-Murray County Medical Society through our Committee on AIDS, and through representation on the Northwest Georgia Interdisciplinary AIDS Task Force, will continue to monitor any changes in the disease of AIDS in our community.

---

The physicians of the Whitfield-Murray County Medical Society have authorized the release of this statement on April 25, 1989.



Robert A. Burns, M.D.  
President, Whitfield-Murray County Medical Society

was in response to the negative community reaction to a 15-bed residence for terminally ill AIDS patients being planned by a monastery in Whitfield County. The Society released this Statement to correct misinformation that was circulating in the community and to explain the need for care of terminally ill patients. Dr. Joy Benson, chairperson of the Society's Committee on AIDS, provided an update on AIDS and helped write this important Statement.

The Society hosted the MAG Board of Directors meeting in June. This provided a firsthand look at some of the inner workings of the MAG. Dr. William Lumpkin served as a Director representing Whitfield-Murray; Dr. William Barnwell was Alternate Director.

In July, Dr. Paul Bradley presented a program on bioethics. He had recently formed an ethics committee at one of the hospitals there. He shared some of the fascinating information he had gathered on this topic.

Dr. James Blackwell arranged an informative series of CME programs which ran monthly from January through April.

Dr. Eddie Marlow finished his 2-year term as president of the 7th District Medical Society. Dr. William Barnwell was elected secretary-treasurer of the 7th District.

*(Ed. Note: The Journal encourages all county medical societies to send us information about their meetings. This report of the activities of one of our county medical societies represents a good example of the manner in which such a society can contribute to their profession and community involvement.)*

## DEATHS

**John Morgan McGehee, M.D.**, of Cedartown, a retired physician died of pneumonia last June in Rome. He was 81.

Dr. McGehee practiced surgery from 1935 until his retirement in 1972. During World War II, he served in the Army in England and France.

Dr. McGehee graduated from Mercer University and received his medical degree from the Emory University School of Medicine. He was a member of the International College of Surgeons and the American Medical Association.

Surviving are his wife, daughters, three brothers, three sisters, and six grandchildren.

\* \* \*

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## QUOTES

*There is a magic in the memory of a schoolboy friendship. It softens the heart, and even affects the nervous system of those who have no heart.*

BENJAMIN DISRAELI

*He is a wise man who seeks by every legitimate means to make all the money he can honestly, for money can do so many worthwhile things, not merely for one's self but for others. But he is an unmitigated fool who imagines for a moment that it is more important to "make the money" than to make it honestly. One of the advantages of possessing money is that it facilitates the maintenance of one's independence. The man head-over-heels in debt is more slave than independent. He cannot look others straight in the eye and carry his head at a self-respecting height. Without a reasonable sense of independence there cannot be experienced the most satisfying brand of happiness.*

B.C. FORBES

*To please, one must make up his mind to be taught many things which he already knows, by people who do not know them.*

NICOLAS CHAMFORT

*Wherever the art of medicine is loved, there is also love of humanity.*

HIPPOCRATES

*The fickleness of the woman I love is only equaled by the infernal constancy of the women who love me.*

GEORGE BERNARD SHAW  
*The Philanderer, II, 1898*



## Justice Revisited

**T**he judge must therefore find out the will of the government from words which are chosen from common speech and which had better not attempt to provide every possible contingency. . . . Thus it is not enough for the judge just to use a dictionary. If he should do no more, he might come out with a result which every sensible man would recognize to be quite the opposite of what was really intended; which would contradict and leave unfilled its plain purpose. . . . So you will see that a judge is in a contradictory position; he is pulled by two opposite forces. On the one hand he must not enforce whatever he thinks best; he must leave that to the common will expressed by the government. On the other hand, he must try as best he can to put into concrete form what that will is, not by slavishly following the words, but by trying honestly to say what was the underlying purpose expressed. . . . And so, while it is proper that people should find fault when their judges fail, it is only reasonable that they should recognize the difficulties. Perhaps it is also fair to ask that before the judges are blamed they shall be given the credit of having tried to do their best. Let them be severely brought to book, when they go wrong, but by those who will take the trouble to understand.

LEARNED HAND  
JUDGE OF THE U.S. CIRCUIT COURT  
2ND COURT

*It has been thought that the purpose of punishment is to reform the criminal; that it is to deter the criminal and others from committing similar crimes; and that it is retribution.*

OLIVER WENDELL HOLMES, JR.  
U.S. SUPREME COURT JUSTICE

**W**E TALK this month of justice. Of good justice and bad. Of thoughtful, creative and meaningful justice. Also of rigid and punitive justice. We talk of justice as vengeance. The beginning was back in May, 1989, this Editor's Corner of that month, with the recounting of a first offender trafficking in cocaine. His adventure started then. It carries on now.

That word, justice, as do so many words in our language, brings to each of us a variety of meanings. To some it connotes clearly the death by execution for rape and murder in this state of ours. To others it masquerades as financial ruin for the philandering husband who dares leave a loving wife. At times, justice comes among us in the form of an Impaired Physician's Program characterized by an understanding that an errant physician, drug dependent and useless, can be effectively brought back into the active practice of medicine rather than condemned by a rigid judicial system to personal and professional ruin.

**H**e walked listlessly into the courtroom. The Superior

Court room. The orange fatigues, the uniform, blazed with startling brightness. The identifying insignia on his back seemed too bold: County Inmate.

The father stiffened. The mother seemed to shudder. We all, the friends, took a deep breath. And so it was that we came to this long awaited day. It had been 9 months since the arrest. Nine months of incarceration with a variety of criminals. Nine months of waiting not for justice only but simply for justice to make up its mind.

A short time earlier that morning the judge had arrived. Only a brief time span before the flaming orange, escorted by the deputy, had walked before us. A proper man he seemed, friendly greetings to all. A clear and helpful explanation to us who were so foreign to his world. So calm and relaxed, or so he seemed to us, in the midst of such shattering decision making. I have thought of the judge on occasion since for so often had they observed of us, we physicians, concerning our calmness in the company of tragedy. So often, too, had I though in regards to this apparent emotional control, this calmness of ours — if you only knew.

But relaxed and comfortable this judge seemed for so momentous an occasion. The arguments came quickly. The plea for the State explained the law. Thirty years and \$100,000. Ten years and \$1,000 as an irreducible minimum. We spoke, testified,

those of us who had come to say that this child now grown to manhood need not be given so harsh a penalty. We seemed to see the child, the man, and not the grievous error of judgment. The judge, perhaps, saw it as we did, but then I thought of the other side of human nature with which he must deal. Of a sudden it seemed I understood him. So sure of himself he seemed to be. So distant from the human tragedy. So calm and yet so fragile. "You are kidding us," I thought.

We had waited long enough. Nine months of uncertainty. Of unpredictability. Of fright. Of pure terror in the middle of the night.

**H**e spoke then, he in the austere, official and intimidating black robe. "I can only follow the law. It tells me what to do." No hope here. Locked into a mandate we found ourselves.

The verdict of one man with the law behind him thundered forth. "Ten years and waive the \$1,000." It was I who shuddered now. The mother sat firm and unmoving. She caught me in an embrace. "Don't worry," she said. "We'll make it."

I thought again back to that time a month or so earlier when she had told me in the face of my unseasoned admonition to her, "I'm not embarrassed. I love him. He's my child. I will never give up!"

It was a silent ride home. He had come to be our child. Our

man. Had justice been done? "No doubt about it," I thought. Was the drug problem any closer to solution? Clearly not. It seemed obvious. Did the judge decide with only the rigid law to comfort him or was there in the decision some faint grasp of the human tragedy involved? Speculation only here it seemed to me.

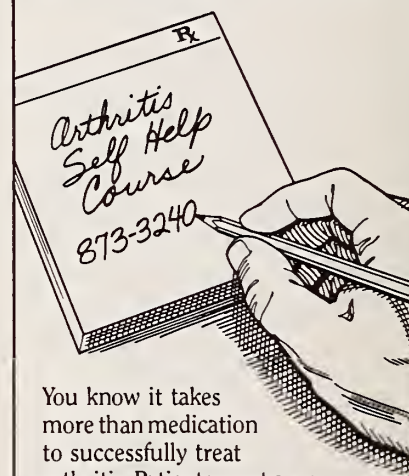
He will be out on parole in a few months. The nine months already served awaiting the meandering vehicle of justice to grind relentlessly to its conclusion will count against the 10 years. An early pardon will shorten the stay. The mother, the father, the family, the friends all will come to grips with the reality of it all. The disappointment, the embarrassment, the dashed hopes and expectations will slowly but surely soften, blur in future vision. And then he will be out. Out to return to this world of ours. To return to the addiction on the street corner. To return to the pimp lurking in the shadows. To return to the freedom of which we seem rightly so proud. To return to the freedom of temptation again. To that exhilarating, gaudy, breathtaking, lifetaking, treacherous freedom. For then the time will come when the child now grown to manhood is on his own again. The time in which we all live. The time of freedom to make of our lives what we will.

We were home now. I shuddered once more. The future lay before me. Lay before him. Open and beckoning.

CRU

## IF YOU DIAGNOSE ARTHRITIS

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TREATMENT CAN  
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The course is taught by certified instructors, and specific treatment questions are always referred to you.

Recommend the Arthritis Self Help Course today. Call the Georgia Chapter of the Arthritis Foundation for more information at (404) 873-3240.





## *Just Too D--- Much Tobacco Raised in Georgia!*

*Sheldon B. Cohen, M.D.*

**S**O SPOKE BETTY MOORE, who keeps my office running smoothly and who incidentally hails from South Georgia. She went on to tell me that tobacco had been the main cash crop when she grew up. Everyone knew this and jumped to the tune of those who dealt in the product. The money from tobacco talks, and legislators indeed listen. This explains why we have only two somewhat mild state statutes and a smattering of local ordinances.

### **Georgia Laws**

1. If a sign in a public place proclaims NO SMOKING ("please do not smoke" doesn't count!), then a fine of \$10 to \$100 can be imposed for those who violate the sign. This enables elevators, motor vehicles, and other public places to have smoke-free areas.
2. Georgia Code 16-12-172 states, "Sales of cigarettes, tobacco, tobacco products, or tobacco-related objects to persons under 17 years of age is prohibited by law." Unfortunately, many Georgia officials do not realize the importance of protecting the health of our young people. Otherwise, why would so many establishments be allowed to sell alcoholic beverages to

underage teenagers? False I.D.s, sometimes not even very good ones, are readily available and usually accepted without question.

**A**lthough we like to think of Georgia as a progressive state, we lag behind the rest of the country in our protection of non-smokers by legislation. As an example, Floridians have the following protections which Georgians do not have (figures in parentheses are the number of other states which also provide this protection): Comprehensive clean indoor laws (25), restricting smoking in public workplaces (31), restricting smoking in private workplaces (14). These include schools, libraries, museums, grocery stores, and theaters. Georgia's minimum age of 17 on sale of tobacco to minors is lower than just about every other state's. We all know the horrible things smokeless tobacco does, especially to teenagers, yet Georgia imposes *no* taxes on smokeless tobacco.

### **Local**

1. City of Atlanta, November 1988, passed an ordinance saying that smoking is allowed in city-owned buildings only in designated areas. In 1986, the city of Atlanta outlawed free

**‘The money from tobacco talks, and legislators indeed listen. This explains why we have only two somewhat mild state statutes and a smattering of local ordinances.’**

distribution of sample cigarettes on the streets with Councilwoman Elaine Valentine stating, "Over 2/3 of the people who start smoking are young people, and those are the ones we are trying to protect. Even if they (the tobacco industry) have rules (against passing out cigarettes to anyone regardless of age), they do not follow them."

2. Among the counties, Fulton, DeKalb, Gwinnett, and Floyd have similar regulations, with Gwinnett prohibiting smoking completely in its new administration building. The

Dr. Cohen practices psychiatry. His address is 490 Peachtree St., Suite 251-B, Atlanta, GA 30308.

**‘Although we like to think of Georgia as a progressive state, we lag behind the rest of the country in our protection of non-smokers by legislation.’**

Rockdale County Fire Department no longer hires smokers. Paradoxically, several months ago when I went to the new Rockdale County Jail to evaluate a prisoner, I was almost asphyxiated as I went through the gauntlet of smoke thrown up by the visitors in the anteroom. The City of Roswell has a smoking ordinance designed to afford protection to restaurant goers. Unfortunately, it is an emasculated caricature of what is needed to protect non-smokers who want to enjoy a meal.

## Preaching What We Practice

Since most physicians are now non-smokers, we should only have a minor tobacco problem. However, many studies have shown that we need to make more diligent efforts to educate and treat our patients. It goes without saying that we should all make our offices, clinics, and hospitals smoke-free. We should encourage our staff to stop smoking, to get help for their addiction, and to provide treatment for addicted patients and/or refer them to appropriate facilities. The more we insure a

healthy environment for ourselves and our patients by making a change, the more credible we are in speaking to legislators, friends, and patients.

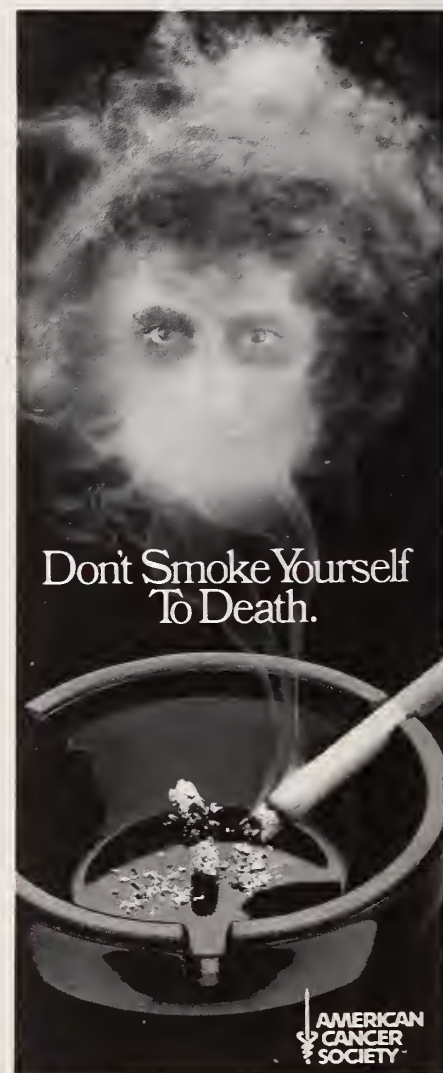
Although they are subject to unbelievably powerful economic pressures by the tobacco industry, we have the power to persuade our city councilmen and women, our state representatives or senators, county commissioners, mayors or governor that health comes first. If such an individual is a patient, we should let him/her know the great danger he/she runs by continuing to use tobacco and offer them help just as we would our other patients. We have to persuade our elected officials that in the long run it is not only for the physical and financial well being of all their constituents but for their own political future that they work diligently for a tobacco-free society. Pragmatically, we should remind them that non-smokers now outnumber smokers by a 3 to 1 ratio, and the figure is growing. Also, since non-smoking voters live on the average seven years longer than smokers and enjoy better health, they are likely to be around a lot longer and vote in many more elections!

## Acknowledgements

Appreciation is expressed to Georgians Against Smoking Pollution (GASP) and the Legislative Clearinghouse of Tobacco-Free America for supplying information.

Information about developing smoke-free communities can be obtained from the Atlanta Coalition Against Tobacco (ACT) or the National Clearinghouse for Smoke-Free Hospitals.

This space contributed as a public service.







## ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

**EDUCATION** Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

**RESIDENCY** Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

**FELLOWSHIP** First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

**OUTSTANDING ACHIEVEMENTS** Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*, Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

“The caliber of physicians you meet in the Army Reserve exposes you to new ways of looking at a problem. It's easy for young surgeons to become entrenched in one method, but in the Army Reserve you'll have the chance to work with outstanding physicians in your own specialty, and often learn new ideas that will help you to improve your own approach to clinical or research problems,” says Dr. Sterling-Scott.

The Army Reserve can offer physicians a variety of challenging options such as teaching, research, unique training programs, and the opportunity to practice in prestigious Army medical centers.

“Joining the Army Reserve enabled me to take advantage of a number of conferences, including one at Walter Reed, where I worked with thoracic surgical colleagues, while conducting my own research project.”

We understand the time demands on a busy physician. So the Army Reserve offers training programs that will allow you to be flexible about the time you serve.

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# THE LOWER RESPIRATORY TRACT— More vulnerable to infection in smokers and older adults



Experience counts

**Ceclor**<sup>®</sup> Pulvules<sup>®</sup>  
250 mg  
cefaclor  
*think of it first*

For respiratory tract infections due to susceptible strains of indicated organisms.

## Summary.

Consult the package literature for prescribing information.

**Indication:** Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci).

**Contraindication:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

## Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in

moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.

- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

## Adverse Reactions: (percentage of patients)

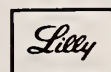
Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
  - As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
  - Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
  - Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.
- Abnormalities in laboratory results of uncertain etiology**
- Slight elevations in hepatic enzymes
  - Transient fluctuations in leukocyte count (especially in infants and children).
  - Abnormal urinalysis; elevations in BUN or serum creatinine.
  - Positive direct Coombs' test.
  - False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly).

[061088L]

Additional information available from  
Eli Lilly and Company, Indianapolis, Indiana 46285.



**Eli Lilly Industries, Inc**  
Carolina, Puerto Rico 00630



## Some New Evidence on the Tobacco Question

*(The following article appeared in a 1912 issue of the JOURNAL. We are still studying the pernicious effects of tobacco more than 70 years later.)*

THE CONSIDERATION of tobacco and its dangers has heretofore been largely based on the amount of nicotin [sic] contained in the smoke. But there are other products of tobacco which must share the responsibility. Among these are carbon monoxide gas, prussic acid, furfural, and some others. Although all of these compounds admittedly are poisonous, their danger depends on the quantities in which they are taken. Recently investigations have been made of some of these toxic products, and the results are of considerable interest. The fact that the action of certain kinds of tobacco has been attributed to the prussic acid in their smoke has induced the Wurzburg hygienist, Prof. K. B. Lehmann, to investigate the charge. He has found that the amount of this compound produced depends somewhat on the rate at which the tobacco is smoked. The slower the current of air through a cigar, the smaller is the amount of prussic acid formed. The entire amount found, however, is too small to account for the effects. So far the burden of the blame for the ill effects of smoking would appear to rest on nicotin. Investigations made by the London *Lancet* indicate that the ordinary cheap cigaret contains the least nicotin in the smoke and the pipe the most, the cigar occupying an intermediate position. Assuming, then, that nicotin is the essentially injurious substance in tobacco, the cigaret would

appear to be the least harmful form, provided that the amount of tobacco consumed was no greater in this form than in others.

The general impression, however, is that cigaret-smoking is the most pernicious form of indulgence in tobacco. This might be accounted for in part by the facts that the form of the cigaret makes it possible for young persons to indulge in it when they would not smoke cigars or pipes, that in older persons it lends itself to overindulgence and that the smoke may be inhaled with less irritation and, therefore, that more of the products may be absorbed into the system. Further investigations indicate that the most injurious forms of smoking are not those in which nicotin prevails but those in which there is a larger proportion of furfural. Furfural is about fifty times as poisonous as ordinary alcohol. There is a probability that the least harmful tobacco will turn out to be that which yields a minimum of furfural in the smoke. Although the amount of nicotin present in the cheaper grades of cigarets is practically negligible, the amount of furfural appears to be sufficient in itself to account for the bad effects attributed to cigaret smoking. The use of tobacco in its various forms is so general that the subject is of almost universal interest. The *Journal of the American Medical Association* thinks that the smoker is entitled to know the dangers and the safest methods of using tobacco, while educators and all who have anything to do with the young, whether by example or by precept, will appreciate scientific facts with which to back up wise deductions from experience.

### **GHA Works to Promote Awareness of Hospital Issues**

**T**he Georgia Hospital Association has begun a program to promote public awareness of the problems and issues hospitals are facing and also to increase the image of hospitals in Georgia.

The Association's first step in that program was to commission a survey of Georgians asking their opinions about the quality of hospital care, hospital costs, cost shifting, health care technology, indigent care, and Medicare, Medicaid, and third-party reimbursement.

GHA will use the findings of the new survey to determine what steps are necessary to create a positive image for hospitals. Those steps will likely include media education programs, conferences, editorial meetings with the larger newspapers in the state, speaking tours, and contacts with legislators.

### **Private Hospitals Could Feel Effects of Abortion Ruling**

**T**he U.S. Supreme Court's decision to uphold a Missouri law banning abortions in public hospitals may, in turn, affect private hospitals as well.

Depending on how an individual state interprets and defines a public facility, private hospitals may come under the ruling. Justice Sandra Day O'Connor even acknowledged that a state "could try to enforce the ban against private hospitals using public water and sewage lines, or against private hospitals leasing state-owned equipment or state land."

According to one survey, 13%

of all abortions are offered in hospitals, and 265 public hospitals offer the service.

In brief, the Missouri law states that public hospitals cannot be used for abortions not necessary to save lives, that public employees (including physicians and other health care providers) cannot perform or assist in abortions not necessary to save the mother's life, and that any fetus thought to be at least 20 weeks old must be tested for viability.

### **Hospitals Paying More For Goods And Services**

**H**ospitals are paying considerably more this year for their non-capital goods and services, according to new data from the American Hospital Association.

The AHA's Hospital Marketbasket Index, which measures the price increases hospitals are experiencing, shows that during the first quarter of this year, marketbasket costs rose at an annual rate of 8.3%. That was up from a 7.2% annual increase during the same period last year. And some forecasters are predicting that prices will rise even higher as the year continues.

Broken down, the price increases for the period looked like this:

- Labor costs — 9.5% annual rate increase for the first quarter of this year as compared to 9% for the same period in 1988
- Food costs — a 6.6% increase for 1989, up from last year's 3.1% increase
- Non-labor goods and services — a 6.4% increase this year, compared to last year's 4.3%
- Non-medical supplies — an increase of 6.9%, up from 3.4% last year.

### **Hospitals' Medicare Receivables Show Increase**

**T**he Healthcare Financial Management Association reports that hospitals' Medicare receivables increase substantially during the fourth quarter of 1988.

According to HFMA, hospitals had an average of 78.5 days of outstanding Medicare inpatient revenue during that period, up from 65.7 days for the third quarter of 1988.

HFMA attributes the increase partly to a 14-day Medicare payment floor that became effective Oct. 1, 1988, and that speeds up payment.

The report also showed that U.S. hospitals provide about \$11.5 billion in uncompensated health care services each year.

### **Radiology Accounts For Greatest Part of Medical Equipment Budgets**

**R**adiology is taking the lion's share of hospital medical equipment budget, according to a new survey conducted by New York City's Shearson Lehman Hutton. Diagnostic imaging equipment accounts for about 27% of overall capital expenditures, which, in turn, account for about 6.7% of the total hospital budget.

Aside from radiology, hospitals' medical equipment expenditures on the average are 14% to the operating room, 11% to the laboratory, 9% to data processing, and 7% to the intensive care unit. The most common purchases planned for the near future in diagnostic imaging are CT scanners, magnetic resonance imaging systems, angiography/catheterization labs, and x-ray machines.

*(This page is sponsored by the Georgia Hospital Association.)*



## It's Over, Mom.

**A**NOTHER TRIP HOME. The 450-mile, 9-hour southward drive was no longer the joyous vacation trip it used to be. Too many trips in a small sedan with flat tires, broken water pump, wife, 10-month infant, playpen, high chair, stroller, and assorted toys have taken their emotional toll. Innocently, last summer began with a 650-mile, northern, 13-hour trip for my wife's grandmother's 91st birthday and family reunion. The weekend will forever be remembered for the time spent with relatives and the spontaneous miscarriage of our second child. A week spent back at work, then southward again we were headed. Word was received, "Come home, she's not doing well."

Nine hours of driving, 540 minutes of consternation. What to expect? Pleural effusions, malignant ascites, spinal cord compression? I've seen all as sequelae of metastatic infiltrating ductal adenocarcinoma of the breast. Four years, 5000 rads of radiation therapy, two surgeries for local recurrences, and bilateral modified mastectomies have passed since that initial needle biopsy showed adenocarcinoma in defiance of yearly negative mammograms. Estrogen receptors were negative. Chemotherapy offered, but declined by the patient. She wanted to be without nausea, vomiting, and anorexia for the upcoming medical school graduation of her oldest daughter and the high school graduation of her youngest.

She a registered nurse, he a pathologist and generalist, two children now physicians and four others in college — such a sight it must have been to see us returning home. To care for her was our way of serving her, for the 34 years she served us.

**M**any trips have passed, 5000 miles have been traveled. Mediastinal, lung, liver and bone metastases now exist. Hoarseness and dysphagia are now present and create such a burden for this woman who so loved to talk. She wanted no hospitalization or intravenous fluids — it would be easier for friends to visit her at home. Now too weak to walk, she remained in her bedroom — cleaned, turned, fed, and cared for by family and friends.

At 7:00 p.m. we entered, afraid of what we'd encounter. A smile, a whispered "Hi Sweetie," and a kiss to little Marie were received. Temples were wasting, eyes protruding, Cheyne-Stokes respirations occurring, extremities were cooling. The rest of the family made arrangements to come home.

She maintained she was in no pain; for that we were grateful. Friends from hospice had provided their latest regimens for caring for the terminally ill. For hours we spent by her, feeding, cleaning, turning, caring, and loving her — thinking of what was and what would be. Conversation was now taxing but hand squeezes continued; never will I forget her gasping, "Oh Tommy, Oh Tommy!" to me.

Sunday morning we awakened, no sound was she making. He was on the phone to mortuary, family, and friends. Tears were shed but relief was felt instead; friends were soon coming in. Prayers we said giving thanks to Our Lord for this day; for the life that once was and for ours still to come.

An unmistakable smile was seen on her face.

It's over, Mom. We love you.

*Thomas J. Hartney, M.D.  
Medical College of Georgia*

## SEPTEMBER

25-16 — *Atlanta: Quantitative Thallium Myocardial Tomography.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-28 — *Atlanta: Advanced Demonstrations in Percutaneous Transluminal Angioplasty XXII.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

25-29 — *Atlanta: Congress of Neurological Surgeons.* Contact CNS, 1840 North Soto St., Room 100B, Los Angeles, CA 90033. PH: 213/224-5435.

25-29 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## OCTOBER

4-6 — *Atlanta: Biliary Lithotripsy and Adjunct Procedures.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-6 — *Atlanta: GA Chapter, American Academy of Pediatrics.* Category 1 credit. Contact William C. Mankin, 4059 Land O'Lakes Dr., NE, Atlanta 30346. PH: 404/237-3922.

9-11 — *Savannah: Neonatology — The Sick Newborn.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-13 — *Atlanta: Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-14 — *Atlanta: Renal Disease Conference.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-14 — *Atlanta: Advances in the Diagnosis and Management of Acute Myocardial Infarction and Ischemia.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

12-15 — *Sea Island: Georgia Orthopaedic Society.* Category 1 credit. Contact Jeff Nugent, M.D., 105 Collier Rd., Ste. 5000, Atlanta 30309. PH: 404/355-0743.

13 — *Atlanta: Recent Advances in the Treatment of Disorders of the Gastroenteropancreatic System/Clinical Applications of Sandostatin (Octreotide Acetate).* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

13 — *Atlanta: Techniques of Flexible Esophagogastroduodenoscopy.* Category 1 credit. Contact Dr. Smith, American Institute of Medical Education and Research Inc., 1526 York Road, Suite 2-E, Lutherville, MD 21093. PH: 301/828-6202.

13-14 — *St. Simon's Island: Nephrology Update 1989.*

Sponsored by The National Kidney Foundation of Georgia. Category 1 credit. Contact NKGK, 1639 Tullie Circle, Suite 108, Atlanta 30329. PH: 404/248-1315 or 800/633-2339.

14 — *Atlanta: Techniques of flexible Sigmoidoscopy, Colonoscopy, & Colonoscopic Polypectomy.* Category 1 credit. Contact Dr. Smith, American Institute of Medical Education and Research Inc., 1526 York Road, Suite 2-E, Lutherville, MD 21093. PH: 301/828-6202.

15 — *Atlanta: Advanced Techniques of Upper GI Endoscopy.* Category 1 credit. Contact Dr. Smith, American Institute of Medical Education and Research Inc., 1526 York Road, Suite 2-E, Lutherville, MD 21093. PH: 301/828-6202.

15-20 — *Atlanta: American College of Surgeons.* Contact ACS, 55 E. Erie St., Chicago, IL 60611. PH: 312/664-4050.

15-20 — *Atlanta: American Society of Colon & Rectal Surgeons.* Contact ASCRS, 800 E. Northeast Hwy. #1080, Palatine, IL 60067. PH: 312/359-9184.

16-20 — *Pine Mountain: The Physician in Management — Seminar I.* Category 1 credit. Contact J. Boyd, American College of Physician Executives, 4830 W. Kennedy Blvd., Ste. 648, Tampa, FL 33609. PH: 813/287-2000.

16-20 — *Pine Mountain: The Physician in Management — Seminar II.* Category 1 credit. Contact M. Taich, American College of Physician Executives, 4830 W. Kennedy Blvd., Ste. 648, Tampa, FL 33609. PH: 813/287-2000.



## *Spring Comes Early* by Jesse L. Parrott

123 pp, paper \$10.00, Tallahassee, Florida, Rose Printing Company, 1988.

**D**R. JESSE PARROTT has subtitled his book "Living through the Golden Age of Medicine." Some of it may not have been so golden but, as Dr. Parrott points out, it was a different time for medicine.

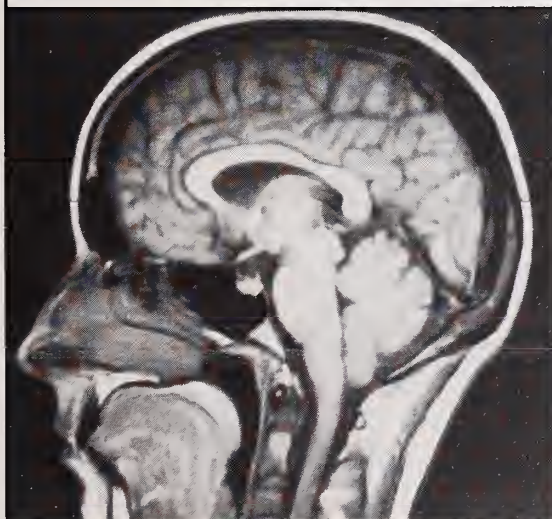
Dr. Parrott, with considerable good humor, takes a few well placed shots at the too often hypertrophied medical ego. He recognizes, however, that physicians of dedication and skill are common and that many "are servants despite the fees." Dr. Parrott is certainly such a

physician. Hahira has been fortunate to have him.

Dr. Parrott writes of his life. The non-medical chapters are interesting, but Dr. Parrott is at his best in describing his practice and his patients. There are messages for everyone in these stories: messages about life, about quiet heroes, about small-towns and families, and suffering and hope.

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# The Health and Economic Burden of Cigarette Smoking in Georgia in 1985

Steven G. F. Wassilak, M.D., J. David Smith, B.S., Thomas W. McKinley, M.P.H.,  
R. Keith Sikes, D.V.M., M.P.H.

## Abstract

**U**sing the estimated prevalence of current and former cigarette smoking among Georgians, death certificate data in 1985, and the available literature on smoking-related health risks, we estimated the health and economic impact of cigarette smoking in Georgia in a single year. We estimated, using relatively conservative assumptions, the mortality and years of life lost prematurely, as well as the costs of medical care for ill individuals, lost wages due to death, and lost wages due to illness attributable to smoking. In 1985, past or present smoking was the cause of death for more than 7,700 Georgians, accounting for over 120,000 years of expected life lost prematurely, and with an overall societal cost exceeding \$1.5 billion dollars. Cardiovascular diseases were the major cause of all estimated deaths associated with smoking. The prevalence of current smokers is higher in Georgians than the national average; this approach to examining the risks may be useful in lowering that prevalence by influencing patient education in Georgia.

## Introduction

**C**IGARETTE SMOKING has been demonstrated in a series of large, well-conducted epidemiologic studies to be a major risk factor for many fatal medical conditions. Although the prevalence of smoking has decreased in the United States in the last 20 years, there remains a substantial proportion of the population who smoke.<sup>1</sup> Further changes in smoking prevalence may require different techniques in education of the lay and medical public than used currently, techniques which translate epidemiologic terms of risk to ideas that can be more readily grasped and used as motivators in changing behavior. One such tool is the calculation of smoking-attributable mortality.<sup>2</sup> Using the esti-

mated prevalence of current smokers and former smokers in Georgia in 1985 and death certificate data, we attempted to estimate the economic and mortality impact that cigarette smoking had on Georgians in that year.

## Methods

The prevalence rates of current smokers and former smokers in Georgia by gender and age group were

obtained from the Current Population Survey of the Bureau of Census for 1985 (Table 1).<sup>3</sup> Tallies of deaths occurring in 1985 due to the diseases related to smoking (Table 2) were made using underlying cause of death listed on death certificates as coded by the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM), by gender and 5-year age-

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**TABLE 1 — Cigarette Smoking Prevalence Rates, by Gender and Age Group, Georgia, 1985**

Gender	Smoking Status	Age (years)	Prevalence Rate
Female	Current Smoker	≥20	26.0%
		20-64	28.7%
		≥65	12.9%
	Former Smoker	≥20	13.9%
		20-64	14.1%
		≥65	12.9%
Male	Current Smoker	≥20	39.2%
		20-64	41.1%
		≥65	25.8%
	Former Smoker	≥20	24.7%
		20-64	22.5%
		≥65	40.9%

groups. Using a software package (Smoking-Attributable Mortality, Morbidity, and Economic Costs — SAMMEC) designed by the Minnesota Department of Health,<sup>4</sup> which is derived from the methodology of Rice et al,<sup>2</sup> the number of deaths attributable to smoking were calculated using the prevalence data and the relative risks of disease in current and former smokers (Table 2). In these calculations, the gender and age-adjusted relative risks of death due to 21 disease categories for current and former smokers were derived from the results of four large studies, except for the determination of risk of ischemic heart disease deaths in women under 65 years of age. For that estimation,

**TABLE 2 — Relative Risks of Death for Current and Former Smokers for Conditions Associated with Cigarette Smoking, by Gender**

ICD-9-CM Category (Codes)	Diagnosis	Relative Risks			
		Current Smoker		Former Smoker	
		Male	Female	Male	Female
<b>I. Adults (≥20 years of age)</b>					
<i>Infectious and Parasitic Diseases</i>					
(010-012)	Respiratory Tuberculosis	2.56	1.00	1.95	1.00
<i>Neoplasms</i>					
(140-149)	Lip, oral cavity, pharynx	6.62	3.25	2.28	1.74
(150)	Esophagus	4.80	4.90	1.65	1.87
(151)	Stomach	1.49	2.30	1.17	1.00
(157)	Pancreas	2.00	1.48	1.37	1.26
(161)	Larynx	7.33	3.25	8.84	1.74
(162)	Trachea, Lung, Bronchus	10.02	3.67	4.47	1.29
(180)	Cervix uteri	—	3.00	—	1.40
(188)	Urinary Bladder	2.30	1.89	1.60	1.94
(189)	Kidney, Other Urinary	1.47	1.50	1.63	1.02
<i>Cardiovascular Diseases</i>					
(401-405)	Hypertension	1.39	1.43	1.21	1.40
(410-414)	Ischemic Heart Disease (<65)	1.88	1.88	1.38	1.30
(410-414)	Ischemic Heart Disease (≥65)	1.49	1.28	1.20	1.27
(427.5)	Cardiac Arrest	3.00	3.00	1.00	1.00
(430-438)	Cerebrovascular Disease	1.32	1.45	1.00	1.28
(440)	Atherosclerosis	1.83	1.94	1.14	2.40
(441)	Aortic Aneurysm	4.46	3.19	2.95	3.01
<i>Respiratory Diseases</i>					
(480-487)	Pneumonia, Influenza	1.79	1.29	1.00	1.17
(491-492)	Chronic Bronchitis, Emphysema	10.13	7.40	10.97	4.89
(496)	Chronic Airways Obstruction	10.13	7.40	10.97	4.89
<i>Digestive Diseases</i>					
(531-534)	Ulcers	2.88	3.21	2.12	2.45
<b>II. Infants</b>					
<i>Perinatal Conditions</i>					
(765)	Short Gestation/Low Birth Weight	1.76*	1.76*	—	—
(769)	Respiratory Distress Syndrome	1.76*	1.76*	—	—
(770)	Respiratory Conditions of the Newborn	1.76*	1.76*	—	—
<i>Signs and Symptoms</i>					
(798.0)	Sudden Infant Death Syndrome	1.50*	1.50*	—	—

\*Risk for children born to women currently smoking



relative risks were modified for current and former smokers in light of more recent data suggesting risks compared to non-smokers of 3.6 and 1.3, respectively;<sup>5</sup> for current women smokers, we assumed a risk relative to non-smokers equal to that used in this analysis for men of 1.88. For the attributable risks of deaths due to three perinatal conditions related to maternal smoking, the data of McIntosh were used along with the prevalence of current female smokers aged 20-64 years.<sup>6</sup>

We also included in our analysis the effects of smoking on deaths due to fires and lung cancer deaths due to passive exposure to cigarette smoke. All deaths in which the underlying cause of death was indicated as an injury (ICD-9-CM codes 800-999) with external cause of fire (E890-E899) were considered fire deaths. Based on a sentinel surveillance system for fires (National Fire Incident Reporting System), approximately 28% of deaths following fires with known cause in the United States were due to smoking in 1983-84.<sup>7</sup> This figure was applied across all age groups in order to estimate the number of smoking-attributable fire deaths in Georgia in 1985. An estimate of the number of lung cancer deaths in Georgia attributable to involuntary exposure to tobacco smoke was made using the midrange of estimated risk applied to the estimated exposed individuals in the nation in the report of the Institute of Medicine on passive smoking<sup>8</sup> and assuming the age distribution of these cancers would be equal to all lung cancers.

Using the gender and age group-specific estimates of deaths attributable to smoking, including perinatal deaths and fire deaths, the years of expected life lost were calculated by subtracting the mid-year of each age group from the average life expectancy, multiplying each value by the estimated number of smoking-attributable deaths for each age group, and summing the result.<sup>9</sup>

Direct costs of smoking-attributable neoplastic, cardiovascular and respiratory diseases were estimated in SAMMEC, which accounts for the costs of health care for persons ill

with these conditions (whether dying or not). Personal health care expenditures for Georgia in 1985 were estimated by examining the per capita national average health care expenditures for 1985,<sup>10</sup> correcting for the per capita expenses for Georgia as a percentage of the national average (88%)<sup>11</sup> and extending this to the 1985 Georgia population. The estimated gross cost figures used are: total personal health expenditures, \$7.9 billion; hospital costs, \$3.5 billion; physician services, \$1.8 billion; other professional services, \$262 million; medications, \$609 million; and nursing home costs, \$742 million. For tuberculosis, gastrointestinal ulcer disease, burns, and perinatal conditions, we crudely estimated the direct health care costs due to smoking by examining all deaths in Georgia that were in the respective medical condition categories as defined by ICD code of the underlying cause of death (infectious and parasitic disease, diseases of the digestive system, etc.). The fraction of all deaths in each ICD medical condition category which were smoking-associated (as derived here) was multiplied by the total personal health care expenditures estimated for Georgia for those medical conditions from the national average expenditures for each category in 1980.<sup>12</sup> For example, for fire deaths, the fraction of all deaths due to injuries that were smoking-associated fire deaths was 0.75%; this was multiplied by the estimated total personal health expenditures for injuries calculated for Georgia, \$690 million.

Indirect mortality costs (lost wages due to premature death) attributable to smoking were estimated using wage assumptions for males and females, including a low wage equivalent for homemakers by the methods of Rice et al.<sup>2</sup> Although not a part of SAMMEC, modification allowed these same calculations for fire deaths attributable to smoking. A discount rate of the current value of future earnings was assumed at 6%. Indirect morbidity costs (those wages lost due to days of illness) were calculated in SAMMEC by assuming a constant rela-

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## **Despite economic arguments for the sale of tobacco products, there are indeed costs due to tobacco use borne by others through insurance payments, Medicare, and worker's compensation.**

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tionship between these costs and the sum of indirect mortality and direct costs. For fire deaths, indirect morbidity costs were calculated assuming a similar ratio for these to other costs as other smoking attributable medical conditions (approximately 23%); these costs were not calculated for smoking-attributable perinatal deaths. All dollar costs are in 1985 dollars.

### **Results**

By our analysis, past or present smoking was the cause of death for more than 7,700 Georgians in 1985, accounting for over 120,000 years of expected life lost, and costing over \$1.5 billion to society at large (Table 3). Deaths attributable to smoking constituted 15.9% of the 48,574 deaths in Georgia in 1985 and 29% of deaths due to the conditions with a relationship to smoking examined here. Although neoplastic, cardiovascular, and respiratory diseases were the major contributors, other smoking-associated causes of death accounted for 3% of these deaths, 8% of the years of expected life lost, and 10% of the costs (Figures 1 and 2). Cardiovascular diseases due to smoking were estimated to have caused 6.6% of all deaths in Georgia in 1985 and were the major cause of all estimated deaths attributable to smoking (41%); however, because these deaths occurred at relatively later ages than those from the other smoking-attributable causes, cardiovascular diseases due to smoking contributed slightly less to ex-



TABLE 3 — Smoking-Attributable Mortality and Associated Costs, Georgia, 1985

Condition	Number of Deaths Attributable to Smoking			Years of Expected Life Lost			Direct Costs	Total Costs
	Male	Female	Total	Male	Female	Total		
Cardiovascular Disease	1,993	1,207	3,200	29,738	17,409	47,147	\$249,397,533	\$ 597,903,41
Neoplasms (All)	(2,231)	(573)	(2,804)	(34,982)	(10,985)	(45,967)	(201,272,602)	(522,981,10
Lung-Direct	1,759	314	2,073	27,445	6,062	33,507	144,986,543	401,681,5
Lung-Passive	32	60	92	499	1,158	1,657	8,071,286	18,556,03
Other	440	199	639	7,038	3,765	10,803	48,304,773	132,743,48
Respiratory Disease	1,091	400	1,491	13,515	6,091	19,606	110,419,678	230,529,93
TB/Ulcer Disease	59	33	92	950	441	1,391	48,704,175	59,623,02
Perinatal Conditions	46	34	80	3,183	2,674	5,857	9,904,782	28,557,48
Fire Injury	34	19	53	1,242	800	2,042	8,522,743	67,246,00
TOTALS	5,454	2,266	7,720	83,610	38,400	122,010	\$628,221,514	\$1,536,840,96

pected life lost and costs. Because of the impact on small children and infants, perinatal and fire deaths due to smoking, which were only 1.7% of smoking-associated deaths, contributed more than 6% of years of expected life lost and costs. Smoking by pregnant women could account for an estimated 6.5% of the 1,222 infant deaths in Georgia in 1985 because of resultant perinatal conditions. Lung cancer due to passive smoking was estimated to cause 92 deaths (1.2% of smoking-related deaths) and alone be associated with a total cost of \$18.6 million.

### Discussion

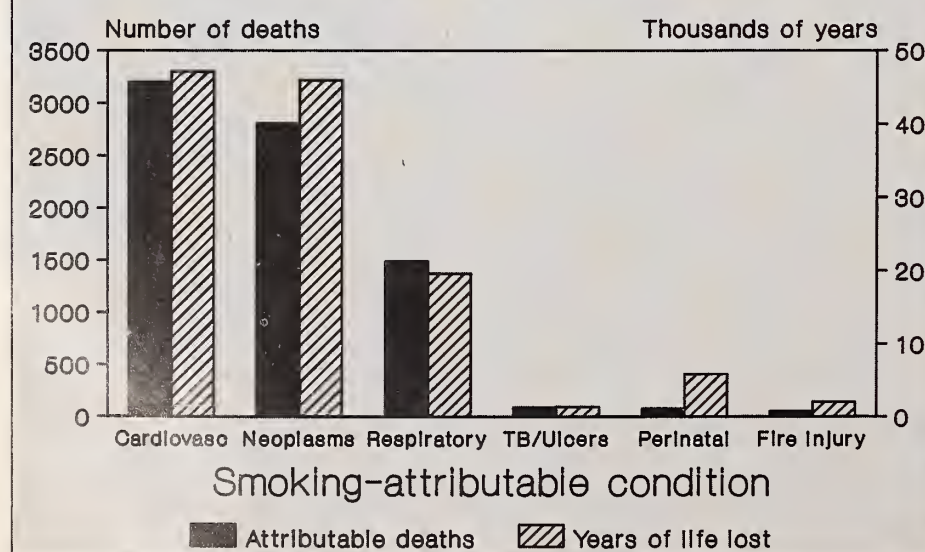
The impact of smoking-attributed disease estimated here is conservative for several reasons. First of all, the estimates for health impact have been minimized: 1) underlying cause of death may not always be listed as such on a death certificate; 2) the risks for some of the diseases of interest are likely to be higher than used in these calculations; this is particularly true for the risks of lung cancer and ischemic heart disease in women, since risks for women smokers have been estimated from earlier studies when women may have inhaled less

smoke; 3) there was no attempt to quantify the health impact of smoking on illnesses with low risks of death, but which are nonetheless related to active smoking (such as asthma) or to passive exposure to environmental tobacco smoke (such as asthma and respiratory infections in children and adults, and otitis media in children);<sup>13</sup> 4) it is likely that passive smoke exposure will also be found to be associated with higher risks of cancers other than lung; and 5) calculation of years of life lost are based on current life expectancy, which is lowered somewhat by the inclusion of smokers in the population.

Second, in addition to these issues, some of the cost estimates may be conservative: 1) the assumption of 6% inflation discounting the current value of future earnings is high, lowering apparent costs; 2) property loss due to fire was not included. Approximately 4% of the costs of all fire damage are due to smoking-associated fires,<sup>14</sup> accounting for a cost of property damage of perhaps over 13 million dollars in Georgia in 1985 from smoking.

Finally, this analysis cannot address other items more difficult to define, such as the number of spontaneous abortions and stillbirths associated with maternal smoking, and the effect of illness of the quality of life for the smoker, as well as on the smoker's family, friends, co-workers, and caregivers. We did not attempt to address the health and

**Figure 1. Health Impact of Smoking in Georgia, 1985**





economic implications of pipe or cigar smoking nor of smokeless tobacco use, despite their known links to neoplasms.

Smoking by men is more common in Georgia (38%) than the national average of 30-33%; in addition, the national trend of a slower decline in smoking prevalence in women to the current 24-28% is a major public health concern for Georgians.<sup>1</sup> What is shown in this analysis are the large number of preventable deaths that occur and years of life lost each year in Georgia due to smoking. Years of potential life lost are often calculated to age 65 to indicate lost "productive" years of life. We calculated loss to life expectancy since premature death after 65 years of age still has an impact on family and others; when calculated as years of potential life lost before age 65, the total is over 30,000. We also wish to emphasize that, despite economic arguments for the sale of tobacco products, there are indeed costs due to tobacco use borne by others through insurance payments, Medicare, and worker's compensation. Although there are arguments that the costs of paying for extended life negates in some way the costs to society saved when death is prevented, others have emphasized that the direct costs of care and wasted human life due to smoking are the most compelling reasons to press toward a "smoke-free" society.<sup>15</sup> While former smokers retain some risks of illness, there is no increased risk of death to former smokers who live 10 years after

quitting. We hope that this information can be useful in formulating smoking policies and patient education in Georgia.

**Acknowledgments**

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**Past or present smoking was the cause of death for more than 7,700 Georgians in 1985, accounting for over 120,000 years of expected life lost, and costing over \$1.5 billion to society.**

Health, Centers for Disease Control for providing advice and comments.

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**The direct costs of care and wasted human life due to smoking are the most compelling reasons to press toward a "smoke-free" society.**

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# PRO Review Part II: Surgical Review Activities

Ralph A. Murphy, M.D., Tom Bennett, R.N., C. Patrick Ryan

*(Part I of this series appeared in the August Journal.)*

ONE OF THE MOST significant aspects of the new review requirements mandated by the Health Care Financing Administration (HCFA) involves the emphasis on invasive procedure review. Although the increased review in ambulatory as well as inpatient settings began in April, 1989, Congressional concern in these areas can be traced back to the original PRO legislation. In recent years, with the dramatic increase in the number of procedures performed each year, legislators have expanded PRO review to ensure the necessity and quality of these procedures.

Section 9401 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 required that PRO contracts specify at least ten (10) surgical procedures be subject to pre-admission and/or pre-procedure review for the purpose of requiring a second surgical opinion where appropriate. At this time, HCFA has not yet promulgated proposed regulations to implement the

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**Initial review of these cases has indicated the need for careful documentation of surgical indications, pre-operative patient assessment, the operative procedure, and post-operative status of the patient.**

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second opinion program; however, GMCF's contract with HCFA included a provision that requires the pre-certification reviews now with implementation of the second opinion program once regulations are finalized.

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It is interesting to note that another section of COBRA 1985 regarding denial of payment for substandard care (Section 9405) has also not been implemented yet, although proposed regulations were published in January of this year.

In addition to the pre-procedure review requirement, Section 9343 of the Omnibus Budget Reconciliation Act of 1986 (OBRA) required that PRO contracts be modified to provide for review of all or, *at the discretion of the Secretary*, a sample of ambulatory surgical procedures performed in ambulatory surgical centers and hospital outpatient departments.

In this article, we describe GMCF's plans to implement these required review activities during Georgia in the next 3 years.

To reiterate, GMCF will be conducting three types of surgical procedure reviews during the current contract. These include:

- (1) Pre-Procedure/Pre-Admission review of 10 procedures
- (2) Retrospective inpatient procedure reviews
- (3) Retrospective ambulatory procedure reviews

## Pre-Procedure/Pre-Admission Review

This review is conducted by phone, generally with the surgical physician requesting prior approval of planned procedures. It is important to note that emergency procedures do not require prior authorization, although they will be subject to retrospective pre-payment review. The initial screening of cases is done by nurse reviewers utilizing criteria which has been developed in consultation with representatives of state medical societies and GMCF physician consultants. This criteria has been distributed to providers across the state and is available upon request.

If the screening criteria are not

met, the case is referred to a GMCF physician consultant who will determine whether the procedure should be approved for medical reimbursement. The physician consultant's decision is based on his/her medical judgement, experience and knowledge. It is important to note that cases not meeting criteria can be approved. The criteria should not be used as an indicator for the necessity of any given procedure. In some cases, the GMCF physician consultant may contact the surgical physician by phone to discuss case specifics during the review process.

We have summarized our pre-procedure review experience for the first 90 days of this contract in Table 1.

**TABLE 1 — Pre-Procedure Review Activity,  
by Type of Procedure, April-June 1989**

<i>Pre-Procedure</i>	<i>April-June 1989</i>
Total cases	12,616
Number referred	245
Number denied	8

<i>Type of Procedure</i>	<i>Number of Cases</i>	<i>% of Total</i>
Cataract (inpatient and outpatient)	7,243	57.41%
Pacemaker	592	4.68%
Turp	1,327	10.52%
Hysterectomy	344	2.73%
Carotid Endarterectomy	383	3.04%
Total Hip	494	3.92%
CABG	653	5.18%
PTCA	612	4.85%
Laminectomy	370	2.93%
Revascularization	519	4.11%
	12,616	100%

We will continue to monitor review results and may select alternate procedures for review during the course of this contract.

### Retrospective Inpatient Procedure Review

This review activity represents just one aspect of the seven components of HCFA's inpatient review requirements. That is, for each hospital discharge selected for review, GMCF must address the following:

- Quality of care

- Appropriateness of discharge
- Necessity of admission
- Necessity of invasive procedure
- Accuracy of payment (DRG validation)
- Coverage
- Liability of provider/beneficiary

These activities have been part of GMCF's past review efforts; however, during this contract, HCFA has required PROs to develop specific invasive procedure criteria. These criteria are used by non-physician

## In this second of a 3-part series of articles on PRO Review, GMCF describes plans to implement the HCFA-required review activities in Georgia during the next 3 years.

reviewers to assist in determining whether a case needs to be reviewed by a GMCF physician consultant.

At this time, we have established criteria for 133 procedures as well as a generic criteria set to cover all other procedures. We are still in the process of evaluating the efficiency and effectiveness of these criteria and expect to modify and add to the current list based on our review experience and input from specialty societies across the state. These criteria have also been distributed and are available upon request. Approximately one-half of the 5,000 hospital cases selected for review each month include one or more of the procedures subject to review. If the GMCF physician consultant determines a specific procedure was not necessary, part or all of the payment to the hospital will be denied. In addition, any payments to the physician will be recovered by the carrier. In all cases, physicians will have twenty (20) days to discuss the case in question before a denial is made. In addition, all denials are subject to reconsideration by a third GMCF physician consultant of the appropriate specialty.

### Retrospective Ambulatory Procedure Review

In addition to the inpatient procedure review and in accordance with OBRA 1986, the Secretary of Health and Human Services has determined that PROs will review a five percent (5%) random sample of ambulatory surgical procedures. HCFA projects approximately 1,000 reviews each month in Georgia. Al-



though we have only recently begun selecting ambulatory cases for review, it appears the volume may be somewhat lower than the HCFA projections.

The focus of this review includes: necessity of the procedure, accuracy of coding, and quality of care. Due to the limited experience of review in the ambulatory setting, GMCF will be conducting all ambulatory reviews offsite, i.e., in GMCF's offices. This approach will enable closer supervision of nurse reviewers during the implementation of this review. As with the other surgical review activities, cases not meeting criteria will be referred to a GMCF physician consultant of the appropriate specialty.

Initial review of these cases has indicated the need for careful *documentation* of surgical indications, pre-operative patient assessment, the operative procedure, and post-operative status of the patient. As with other reviews, GMCF has developed specific criteria to assist nurse reviewers. Cases not covered

by specific criteria will be referred for physician review. Additional criteria will be developed during the course of the contract.

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**We want to stress the importance of involving practicing surgeons in the development and distribution of criteria to be used by non-physician reviewers in the initial screening of these cases.**

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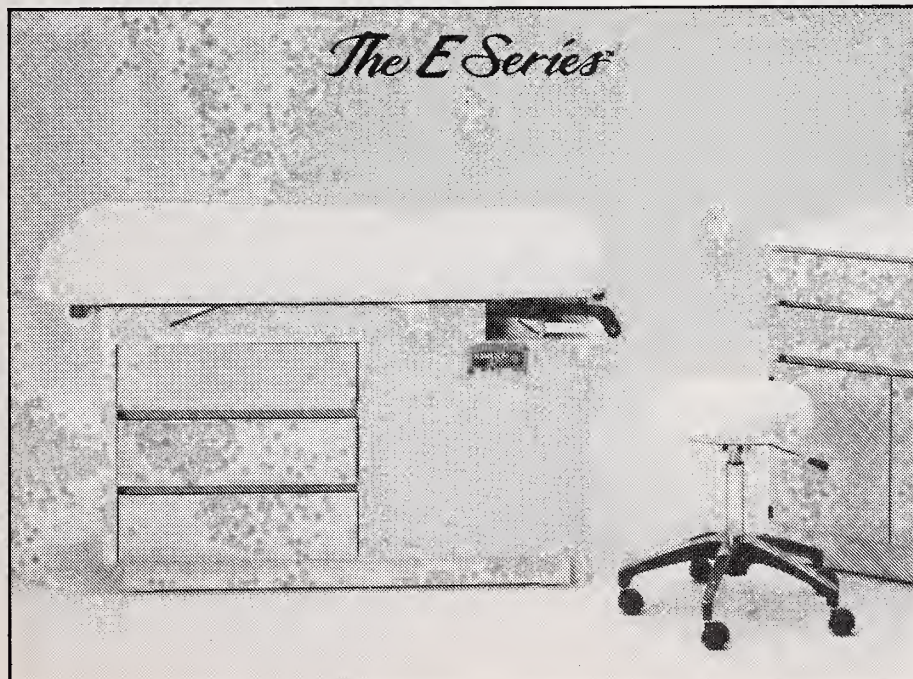
### Conclusion

We have described the key aspects of the GMCF surgical review program during the third Scope of Work. We have stressed the importance of involving practicing surgeons in the development and distribution of criteria to be used by non-physician reviewers in the initial screening of these cases. We will continue to work with representatives from various specialty societies to refine existing criteria as well as develop new criteria for specific procedures as our review experience dictates.

We have also discussed several aspects of the review process itself, including the role of non-physician reviewers, the involvement of appropriate specialists in making determinations, and the appeals rights of practicing surgeons when adverse determinations are made.

In another article in this series, we will describe in detail the steps GMCF will take in addressing quality issues identified during the review process.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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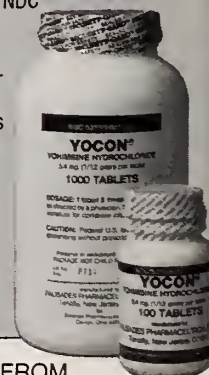
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# One Internist's View of the RBRVS

James K. Van Buren, M.D.

**F**OR MANY YEARS, internists and other primary care physicians have been concerned about the undervaluation of the so-called "cognitive services," those services of evaluation and management that are the cornerstone of our practice and that, indeed, most all physicians provide. The inequity in payment and reimbursement for these services is longstanding and deeply rooted in the current "customary, prevailing and reasonable" or CPR method of payment presently used by Medicare.

In January, 1981, an American Society of Internal Medicine Task Force on Cognitive Services developed and published a white paper entitled, "Reimbursement for Physicians Cognitive and Procedural Services." By June, 1982, meetings with other primary care specialties and subspecialties, including the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Psychiatric Association had taken place to discuss payment for cognitive services. Further discussions with these colleagues and testimony at hearings on Capitol Hill in Washington, D.C., over the next 3 years culminated in September, 1985, with the Health Care Financing

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**Many legitimate questions concerning the validity of the RBRVS study have been raised. We believe that the Harvard investigators more than satisfactorily answered these questions and that the study is valid.**

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Administration (HCFA) awarding a multi-year contract to Harvard University with the AMA as a primary subcontractor to construct a Resource Base Relative Value System (RBRVS) for physician reimbursement. This type of system based on previous studies would address these inequities in reimbursement.

It has been the general consensus among medical, political, business, insurance payers, and patients that there is need for payment reform in the medical field. The CPR is inflationary, expensive, complex,

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Dr. Van Buren practices internal medicine and is presently President of the Georgia Society of Internal Medicine. His address is 490 Peachtree St., Ste. 250-B, Atlanta, GA 30308.

This paper was presented as a speech to MAG's Leadership Conference held last February in Atlanta.

and unpredictable for both physicians and patients. Alternative methods of payment usually fall into one of four categories: physician DRGs, capitation, piecemeal reduction in charges, and fee schedules. For many reasons, the first three alternatives are unacceptable. Most physicians, the AMA, and very importantly, the Physician Payment Review Commission (PPRC), an independent influential body appointed by Congress to advise Congress on these payment issues, have concluded that an indemnity fee schedule offers the best alternative. The RBRVS has evolved as the major player in adapting such a fee system to the inevitable payment changes that are forthcoming.

**M**any legitimate questions concerning the validity of the RBRVS study have been raised. Questions of methodology, size of sample, physician input into the study, to mention a few, have been asked. We believe that the Harvard investigators more than satisfactorily answered these questions and that the study is valid.

The development of the RBRVS involved seven different steps:

1. Define what is meant by "total work."

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**We don't look on this study as a devious issue within medicine, but rather one of healing an old wound that we have recognized for a long time.**

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2. Develop a method of measuring total work within each surveyed specialty.

3. Develop a method to compare work in different specialties.

4. Conduct a national survey of physicians to obtain estimates of work.

5. Extrapolate surveyed services/procedures to other services.

6. Factor in specialty specific training and practice costs.

7. Link specialty-specific RBRVS on a common scale.

To do this, they developed a panel from 23 specialties and six internal medicine subspecialties from a list prepared by the AMA. Time and again independent groups, such as the Consolidated Consulting Group, a nationally recognized group of health economists and healthy policy analysts commissioned by the AMA, have evaluated the RBRVS and found the methodologies and statistical evaluations to be sound and reproducible.

There are, of course, limitations. This study did not take outcomes or quality of service into consideration. The RBRVS is based on the CPT-4 classification which has its own limitations. And very impor-

tantly, it does not consider patient demand for services, i.e., volume. We recognize that there are still unresolved methodologic questions such as the allocation of specialty training and office practice costs within a given specialty, the inter-service variations in practice costs, and the consideration of bundled versus unbundled global services. However, we do NOT believe these limitations are enough to invalidate this study. Much work needs to be done, but the study needs to be accepted and implemented. We believe correction of these limitations

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**The RBRVS has evolved as the major player in adapting an indemnity fee schedule to the inevitable payment changes that are forthcoming.**

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can be accomplished as the system is implemented and phased in. We believe that the time to do that is now. We thus believe that the basic findings and concept in this study are valid. And we believe that the negative impact on most physicians will be minimal.

The recent report from the AMA's Center for Health Policy Research noted that most physicians will benefit from such reforms, that 75% of physicians will gain or lose no more than \$1000 of revenue from Medicare, that only three specialties will experience major reductions in revenue, and even within

these specialties the maximal impact will be felt by a small percentage of physicians practicing in those fields. Even after these reductions, those few specialties will receive substantially higher payments from Medicare than will primary care physicians and, indeed, most of their colleagues in surgical and other specialties.

We believe that reform is coming whether we want it or not. The PPRC must present a report to Congress by March 31, 1989, and HCFA by June 30th, with Congress to begin implementation in 1991. We believe the RBRVS to be the best tool for addressing this reform and that, indeed, all of medicine will benefit. We believe that it is imperative that medicine speak with a unified voice on this issue and speak now.

**I**n conclusion, we don't look on this study as a devious issue within medicine but rather one of healing an old wound that we have recognized for a long time. To quote Dr. Joseph Boyle, a former practicing internist, a past president of the AMA, and now Executive Vice President of the American Society of Internal Medicine, "The Harvard study report represents a great deal more to internists than just reimbursement issues. It is a social statement which says loudly and clearly that the services of our specialty — downgraded, diminished, treated with disrespect by the current payment systems — are, in fact, a far greater worth than has been ascribed to them in the past 20 years. We seek not only equitable treatment, but appropriate recognition of that value and will not give up in that quest."



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# MRI UPDATE

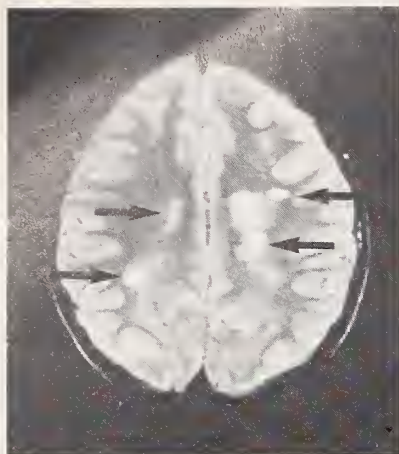


Figure 1

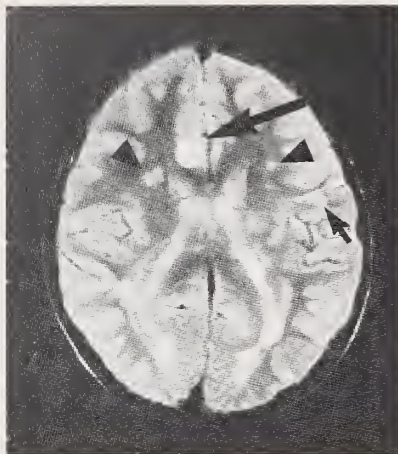


Figure 2

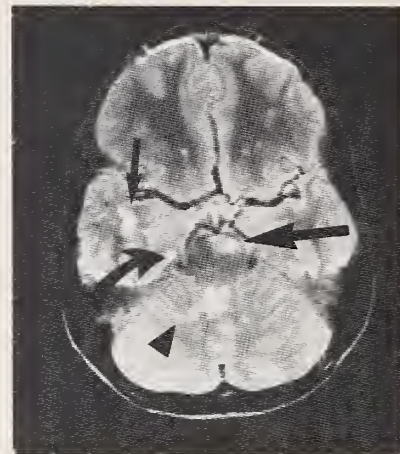


Figure 3

## CLINICAL INFORMATION:

Recently, there has been much discussion in the literature of the neurological symptoms caused by the spirochete *Borrelia burgdorferi*. The disease is transmitted by a tick bite and is associated with clinical symptoms of headaches, multiple arthralgias, and non-specific neurological symptoms. Given the appropriate clinical history, a diagnosis of Lyme disease can readily be confirmed by an MR scan.

**FINDINGS:** Figure 1 is a T2-weighted axial image through the brain. Abnormal focal areas of increased signal intensity can be identified within the centrum semiovale bilaterally (small arrows). These lesions are primarily located within the white matter but are of differing sizes. Figure 2 is also an axial image through the brain but at a level through the lateral ventricles. This section shows a

lesion located within the medial gray matter of the right frontal lobe anterior to the corpus callosum (large arrow). Additional areas of abnormal increased signal intensity can be identified adjacent to the occipital horns, in the gray-white matter interface of the left parietal operculum (small arrow), and in the deep white matter of the frontal lobes in the region of the anterior corona radiata (arrowheads). Figure 3 is through the posterior fossa as well as the lower frontal and temporal lobes. Abnormal areas of increased signal intensity are demonstrated in the left anterior pons (large arrow) in the anterior right temporal lobe (small arrow), in the right cerebellar peduncle (arrowhead), and in the medial right temporal lobe (curved arrow).

The MR images clearly demonstrate the predominantly white matter involvement, multifocal nature, and the absence of

mass effect associated with these lesions. In the absence of clinical history, the MR appearance would be most consistent with a demyelinating process such as multiple sclerosis. However, as this case presented in a nine year old male following exposure to ticks, the differential diagnosis becomes that of Lyme disease. The diagnosis was further confirmed by the findings of similar, although less extensive lesions, in the patient's sibling.

**COMMENT:** The patient in the case above had a CT scan prior to the MR study which was negative. This case clearly demonstrates the increased sensitivity of MR over CT in detection of white matter processes. However, the case also demonstrates the relative non-specificity of the findings. In this case, the clinical history was most important in determining the true etiology of the patient's findings.



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# A Review of Georgia SIDS Autopsy Reports for a 2-Year Period

Barbara N. Samuels, M.D., M.P.H., Susana Rubio-Freidberg, M.P.H.

**A**UTOPSIES PLAY a definitive role in the diagnosis of Sudden Infant Death Syndrome (SIDS).<sup>\*</sup> Acceptance of this role has improved the autopsy rates for presumed SIDS victims in Georgia from 49% in 1980 to 65-70% since 1982.<sup>1</sup> How adequate are these autopsies? Literature review suggests that the SIDS autopsy include a careful medical history, thorough external and internal examination, selected histology review, and total body X-ray.<sup>2,6</sup> While microbiology (bacterial and viral cultures) and toxicology studies are sometimes recommended,<sup>5,6</sup> the yield is so low and positive microbiology results are so often contaminants that most do not consider these procedures routine,<sup>2,4</sup> except, perhaps, for bacterial cultures of heart blood, and lung tissue.<sup>3</sup> Biochemical determina-

## Abstract

**Procedures carried out in autopsies of presumed sudden infant death syndrome (SIDS) victims in Georgia during 1983-1984 were compared to standard criteria found in the literature and in a Georgia publication. One hundred fifty-one complete autopsy reports were available for the study. Although autopsies did not change the presumed cause of death for most SIDS victims, less than half the autopsies included what some experts believe to be an adequate basis for determining SIDS as the cause of death — a careful medical history, a thorough external and internal examination, selected histologic review, total body X-ray, and (perhaps) cultures of heart, blood, and lung tissue. The autopsies compared more favorably to a published Georgia standard that did not include the medical history, but they still overutilized toxicology screening, underutilized microscopic study, and rarely recorded any rationale for performing ancillary procedures.**

tions of urea and electrolytes using vitreous humor, once thought to be indispensable, are no longer considered useful.<sup>†3</sup>

At the time of this study, Dr. Samuels was the Perinatal Epidemiologist for Georgia (Office of Epidemiology Division of Public Health, Georgia Department of Human). She is currently the Bureau Chief of Community Health Services, Texas Department of Health, 1100 West 49th St., Austin, TX 78756. Also at the time of this study, Ms. Rubio-Freidberg was in the Master of Public Health Program at Emory University.

An autopsy protocol for presumed SIDS deaths has been published in Georgia.<sup>‡</sup> It outlines what causes of unexpected death should be considered; the microscopic sections to obtain, the pertinent areas to evaluate in the gross external and internal examinations, and ancillary procedures to perform as indicated (total body X-ray, biochemical determinations using vitreous humor, bacterial and viral cultures, and toxicology). Thus, it differs slightly from the literature by de-emphasizing the X-ray and heart blood, and lung cultures (neither are routinely recommended by all authors); still suggesting biochemical determinations using vitreous humor, and not mentioning the medical history.

The purpose of this study was to determine what procedures were or



were not done based upon the locally developed protocol. The authors neither of whom are pathologists, examined 161 autopsy reports for SIDS deaths that occurred in Georgia during 1983-1984 at the Georgia Bureau of Investigation (GBI) near Atlanta. Georgia law requires autopsy reports be sent to the GBI Forensic Science Laboratory. As reported elsewhere, 80% of the autopsies performed on SIDS victims for these 2 years were actually sent to GBI.<sup>1</sup>

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**Compared to the Georgia protocol, the autopsies appeared more complete, but it can be argued that by omitting the medical history, the protocol itself needs to be updated.**

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### Methods

To obtain autopsy reports from GBI, names, death certificate numbers, and county of death were retrieved from death certificates for SIDS victims who died during 1983-1984. The number of autopsies performed for this cohort based upon the death certificate data and the number of complete, incomplete, and missing files at GBI have been recorded elsewhere.<sup>1</sup> One hundred sixty-one reports were available for this study: 151 were complete autopsy reports; three, police investigation reports; and seven, toxicology reports.

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\* SIDS is defined as the unexpected sudden death of an apparently healthy infant that remains unexplained even after an adequate autopsy. By definition, it is a diagnosis of exclusion, requiring a post-mortem examination to rule out other plausible causes of death.<sup>1,7</sup>

† In situations where autopsies cannot be obtained because of family concerns or other circumstances, a complete history, thorough external examination, and whole body X-ray can be quite accurate in the presumptive diagnosis of SIDS.<sup>3</sup> Steinschneider would add a spinal tap to rule out septicemia (personal communication).

‡ The local protocol was found in the monograph *Sudden Infant Death Syndrome: A Guide for Medical Examiners*, prepared by The Georgia Sudden Infant Death Syndrome Project.

A two-page abstract form was used to collect data from each autopsy. The form was an amalgam of procedures suggested in the literature and in the Georgia protocol. A listing of the items on the abstract form appears in Table 1. Each item was marked "yes" or "no" which signified that an item was or was not done. "Yes" and "no" had no correlation with positive or negative findings.

A pilot test was performed on the first 10 complete autopsy reports found in GBI files for 1982. Each author reviewed the same 10 files, and differences of interpretation were discussed and resolved. One author (SRF) reviewed all 161 autopsy, police, and toxicology reports. Midway through the abstraction period, 10 reports were reviewed by both authors and minor differences of interpretation, particularly involving the toxicology section, were again resolved. All autopsies reviewed prior to this period were rechecked (SRF) and discrepancies corrected.

Percentages for each major category were based upon the number of complete autopsies (151). Percentages for each subset were based upon the number of reports in that major category. Percentages for toxicology items included complete autopsies plus the seven toxicology reports.

Approval to obtain information from death certificates and autopsy reports was obtained from the Emory University Human Investigation Committee. Confidentiality was assured by erasing all names at the end of the study and aggregating the data in such a way that the information could not be traced back to a particular individual.

### Results

Two deaths (1%) listed as SIDs on the death certificate were thought not to be SIDS. One was attributed to glomerular nephritis by the pathologist who performed the autopsy. The second was reviewed at our request by a GBI forensic scientist and a national SIDS expert who felt that the child's history of subdural hematomas and hydrocephalus, among other neurologic

problems, and the autopsy findings were not consistent with SIDS. In six cases, autopsies uncovered anomalies. Two of these were cardiac and apparently known by the family. The other four were renal. Four victims had siblings who died from SIDS. One of these infants had used an apnea monitor. Numbers and percentages for each of the remaining categories and subcategories appear in Table 2.

Only 42% of the complete reports included a medical history of the events preceding death. Another 11% described the scene of death. One third of those with a medical history appeared to have a mild illness; 14% were noted to be on medication, 33% had concurrent health problems. Sixteen percent had been preterm deliveries.

Almost 100% of the autopsies included both an external and an internal gross examination. Most external gross examinations recorded growth and development of the infant (99%), the nutritional status of the body (63%), and the nares (75%). Twenty-six percent noted the presence or absence of anomalies; 49%, of injuries; only 5%, of rashes. Most of the internal gross examinations noted the presence or absence of petechiae on the thymus, pleura, and/or pericardium and the general appearance of the heart (99%), lungs (99%), trachea (77%), and larynx (75%). Sixty-eight percent retained slides for histology, but only 49% reported any results. Approximately one-third included tissue blocks from all but one or two of the organs listed in the Georgia protocol, but only one autopsy included slides from all recommended organs.

Eleven percent of the autopsies included bacterial cultures. Sixty-nine percent of these were blood cultures; 56%, cultures of lung tissue. All reported positive results were thought to be contaminants. Two autopsies also included viral studies. One was reported as polio, the result of a DPT immunization. One autopsy included requests for bacterial, viral, and fungal cultures, but results were not recorded. Almost two-thirds of the cultures were obtained in the absence of any re-



corded medical history or indication for microbiologic investigation.

A total of 107 (71%) of the complete autopsy reports included toxicology screening. Seven more were toxicology reports only. All but one of the 114 total toxicology requests included blood screening. Eighteen percent also included liver specimens. Ninety-five percent requested alcohol levels; 89%, CNS-acting agents such as barbiturates and sedatives; 50%, salicylate levels; 9%, carbon monoxide; and 15%, other toxics such as heavy metals.

Eleven percent of the autopsies included a whole body X-ray. All were done to rule out trauma. Biochemical analysis of vitreous humor was never requested. Ten percent included other procedures like photographs and diagrams of the body.

### Discussion

If autopsies in suspected SIDS cases should include, at least, a careful medical history, thorough external and internal examinations, selected histology, and, perhaps, whole body X-ray and cultures of heart blood and lung tissue, then

less than half the autopsies were adequate. Compared to the Georgia protocol, the autopsies appeared more complete, but it can be argued that by omitting the medical history, the protocol itself needs to be updated. Medical histories were recorded in less than half the autopsies. Gross external and internal examinations were done in almost all cases, with emphasis on the general condition of the infant; the nares; the presence of petechiae in the heart, pleura, and epicardium; and cardiorespiratory systems as suggested by the local protocol. While the value of routine toxicol-

TABLE 1 — Autopsy Checklist

General Comments:	Case No. Card No.	General Comments:	Case No. Card No.
<b>EXTERNAL</b>		<b>MICROBIOLOGY</b>	
Body Length	_____ yes _____ no	Bacterial cultures of:	
Body Weight	_____ yes _____ no	heart blood	_____ yes _____ no
Developmental status	_____ yes _____ no	spleen	_____ yes _____ no
Nutritional status	_____ yes _____ no	each lung	_____ yes _____ no
Hydration status	_____ yes _____ no	larynx swab	_____ yes _____ no
Examination of nares	_____ yes _____ no	stool	_____ yes _____ no
Presence/absence of:		CSF	_____ yes _____ no
rash	_____ yes _____ no	Viral cultures of:	
anomalies	_____ yes _____ no	heart	_____ yes _____ no
injury	_____ yes _____ no	lungs	_____ yes _____ no
Comments:		kidney	_____ yes _____ no
		GI tract	_____ yes _____ no
		brain	_____ yes _____ no
<b>INTERNAL</b>		<b>TOXICOLOGY</b>	
Evidence of petechia in:		Collection:	
thymus	_____ yes _____ no	blood (5-10 ml	_____ yes _____ no
pleura	_____ yes _____ no	whole blood)	
epicardium	_____ yes _____ no	liver (about 10 gr)	_____ yes _____ no
Heart	_____ yes _____ no	CSF	_____ yes _____ no
Lungs	_____ yes _____ no	urine	_____ yes _____ no
Epiglottis	_____ yes _____ no	gastric contents	_____ yes _____ no
Larynx	_____ yes _____ no	For determination of the	
Trachea	_____ yes _____ no	presence and levels of:	
Comments		common agents	_____ yes _____ no
		acting upon	
<b>MICROSCOPIC SECTIONS</b>		the CNS	
(or wet tissue blocks)		salicylates	_____ yes _____ no
Heart	_____ yes _____ no	carbon monoxide	_____ yes _____ no
Lung	_____ yes _____ no	other agents	_____ yes _____ no
Ileum	_____ yes _____ no	appropriate to	
Kidney	_____ yes _____ no	the case	
Liver	_____ yes _____ no	Comments:	
Pancreas	_____ yes _____ no	<b>ADDENDUM</b>	
Spleen	_____ yes _____ no	Total Body X-ray	_____ yes _____ no
Adrenal	_____ yes _____ no	(to look for evidence of excessive	
Trachea	_____ yes _____ no	battering)	
Thymus	_____ yes _____ no	Biochemical	_____ yes _____ no
Brain	_____ yes _____ no	determinations using vitreous humor	
Comments:			

**TABLE 2 — Items Completed in Autopsy Reports. Georgia, 1983-1984.**

<i>Procedure</i>	<i>#Completed</i>	<i>(%)*</i>
<b>MEDICAL HISTORY</b>	64	(42)
Mild illness	22	(34)
On medication	9	(14)
Concurrent problems	21	(33)
Preterm	10	(16)
Sibling SIDS victims	4	( 6)
<b>SCENE OF DEATH DESCRIPTION</b>	17	(11)
<b>EXTERNAL EXAMINATION</b>	150	(99)
Growth & development	149	(99)
Nutritional status	95	(63)
Hydration status	3	( 2)
Nares	112	(75)
Presence of:		
rash	7	( 5)
anomalies	39	(26)
injury	73	(49)
<b>INTERNAL EXAMINATION</b>	150	(99)
Presence of petechiae: (heart, pleura, epicardium)	149	(99)
Heart	148	(99)
Lungs	149	(99)
Epiglottis	3	( 2)
Larynx	113	(75)
Trachea	115	(77)
<b>HISTOLOGY</b>	103	(68)
Heart	70	(68)
Lung	76	(74)
Ileum	15	(15)
Kidney	64	(62)
Liver	69	(67)
Pancreas	48	(47)
Spleen†	65	(63)
Adrenal	56	(54)
Trachea	6	( 6)
Thymus	52	(50)
Brain	64	(62)
Findings reported	50	(49)
<b>MICROBIOLOGY</b>		
Bacterial	16	(11)
Blood	11	(69)
Lung	9	(56)
CSF	3	(19)
Viral	2	( 1)
Fungal	1	( 1)
<b>TOXICOLOGY</b>	114	(71)‡
Blood	113	(99)
Lung	20	(18)
Urine	12	(11)
CSF	0	( 0)
GI	12	(11)
Agents acting on CNS	102	(89)
Alcohol	108	(95)
Aspirin	57	(50)
Carbon monoxide	10	( 9)
Other	17	(15)
<b>TOTAL BODY X-RAY</b>	16	(11)
<b>BIOCHEMICAL TESTS (VITREOUS HUMOR)</b>	0	( 0)
<b>OTHER PROCEDURES (PHOTOGRAPHS, DIAGRAMS)</b>	15	(10)

\* Percentages for major categories (CAPS) were based upon 151. Percentages for minor categories were based upon the total for that category. For example 34% of the 64 autopsies that included a medical history had a minor illness.

† Microscopic sections from the spleen were not on the list of recommended tissue sections in the local protocol.

‡ The 71% refers to the 107 toxicology requests that were part of an autopsy; the other 7 were toxicology reports only. Percentages in the subcategories are based upon 114.

ogy and microbiology investigation is questioned by many experts, more toxicology studies were performed than an other procedures except the gross external and internal examinations. Requests for toxicology screening appeared to be routine rather than based upon suspicion, despite the recommendation in both the Georgia standard and the literature that toxicology testing be requested only if indicated and time, funds, and facilities permit. Microbiology studies were rarely requested. This would appear to conform to the local protocol recommendations that cultures be performed only if indicated, but most cultures obtained were not correlated with a history of minor illness or suspicion of an infectious process. There was no obvious reason for the request of the one fungal culture. Total body X-ray was also not often performed. While some experts believe that total body X-ray is a routine procedure in SIDS autopsies; based upon the Georgia protocol, X-rays are an ancillary procedure to be done, like microbiology and toxicology, only if indicated. The few X-rays requested were done to rule out trauma, but there were no recorded indications that trauma or child abuse were suspected in any of these cases.

Only one cause of death (still listed as SIDS on the death certificate) was officially altered. A presumptive wrong cause of death was also found. This is consistent with preliminary findings of a national, six-center collaborative SIDS research project where the diagnosis of SIDS as the cause of death was changed in only six of 385 cases (2%) after histologic and background information was reviewed by a panel of experts.<sup>7</sup> However, both these percentages are lower than that of a London study where the original SIDS diagnosis was changed in 20 of 98 cases and added to in another five.<sup>8</sup> Eight percent of the 102 SIDS victims brought to a Dublin, Ireland, children's hospital had their diagnosis changed after postmortem examination.<sup>4</sup> Valdes-Dapena estimated that autopsies will not yield an alternative explanation for death in as many as 85%



of suspected SIDS cases with a negative history and unremarkable external appearance.<sup>3</sup> This figure is similar to the aforementioned preliminary study where an unequivocal diagnosis of SIDS was made in 78% of autopsied victims.<sup>7</sup>

With so few diagnosis of SIDS changed by autopsy, at least in the U.S. why bother? Valdes-Dapena argues that an autopsy may be of importance to the family to alleviate fears that they did or did not do something that contributed to their infant's death.<sup>3</sup> Moreover, as found in several infants in this study, an autopsy might uncover congenital or genetic lesions which, while not the direct cause of death, may be of importance to the family planning on more children.<sup>3</sup> In addition, she argues that families have a right to know what caused their infant's death, whether it was an infection, an anomaly, or, in fact, SIDS.<sup>3</sup> For this to happen, an autopsy must first be requested, and then, a minimally useful number of procedures must be performed during that autopsy.

Neither of those happens to the extent possible in Georgia despite the Georgia Post-Mortem Act that outlines procedures for autopsy procurement in unexpected, sudden deaths<sup>1</sup> and a published protocol that outlines steps to be taken during an autopsy of a suspected SIDS victim. As reported earlier, 65-70% of all presumed SIDS deaths in Georgia were autopsied between

1982-85. From 1983-84, only 55% were autopsied if the death was certified by someone other than a medical examiner compared to 96% when a medical examiner certified the death.<sup>1</sup> When autopsies are performed, less histology and more toxicology investigations occur than national or state publications recommend. Less medical histories are recorded and fewer total body X-rays requested than the literature suggests. That these are not emphasized in the Georgia protocol might indicate that the protocol itself should be revised. Indications for performing ancillary procedures (particularly, toxicology and microbiology) are not clear, or at least, not recorded in most autopsy reports. There appears to be a need to educate those in the death investigation system not only to obtain autopsies in suspected SIDS cases but also to perform those autopsies in a manner that provides an accurate basis for assigning a cause of death.

#### Acknowledgements

The authors would like to thank Byron Dawson, Ph.D., Assistant Director of the Division of Forensic Science of the Georgia Bureau of Investigation, for his help and patience, and Susan Williamson, now at the Georgia Nursing Association, whose ideas were the impetus for the study. We would also like to thank Frederic D. Kennedy, Ph.D., of Emory University, Thomas

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**Emphasizing the need for autopsies in suspected SIDS cases must be accompanied by an understanding that autopsies be performed in a manner sufficient to rule out other causes of death.**

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McKinley, M.P.H., and Catherine C. Murphy, M.P.H., of the Georgia Department of Human Resources, and Alfred Steinschnider, M.D., of the American SIDS Institute for help with the manuscript.

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# Effect of Oral Zinc Supplements on Diaper Rash in Normal Infants

Platon J. Collipp, M.D.

## Introduction

**S**EVERAL studies have documented a reduction in the serum and hair zinc concentration during the first few months of life in normal newborn infants.<sup>1-6</sup> Breast-fed infants have been shown to have a smaller decline in hair zinc concentration than formula fed infants.<sup>6</sup> The zinc concentration in human milk and infant formula is similar, but human milk contains a zinc binding ligand which improves zinc intestinal absorption, and infant formula is iron fortified which will reduce zinc absorption. Increasing the zinc content of infant formula was reported to increase the growth rate of normal infants.<sup>7,8</sup> Hair zinc concentration was lower in infants during their first year with diaper rash than in those with no diaper rash.<sup>9</sup> This study reports the effects of oral zinc supplements on growth, thrush, and diaper rash in normal infants.

## Methods

All normal newborn infants seen in my practice in a 1-year period were included in this study. No solid

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**The average infant that received oral zinc supplements gained more height and weight than the average placebo infant, although the difference was not statistically significant.**

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foods were given during the study, and the infants all received milk, water, and vitamin supplements (A,C,D, and fluoride). All infants weighed between 1,920 and 4,860 gms at birth. Diaper rashes were primarily monilial, rather than ammoniacal dermatitis, and all were treated with an anti-fungal cream. All infants were seen monthly until 4 months of age and were weighed and examined by the same physician. There were 36 boys and 53 girls in the zinc supplement group and 40 boys and 50 girls in the pla-

cebo group. The average birth weight and average length were identical in both groups (3,680 gms and 51.6 cm, respectively).

Every mother gave informed consent to participate in the study. Infants began 10 mg oral zinc (gluconate) supplements on the first or second day of life and continued until age 4 months. Placebo consisting of calcium sulfate 220 mg and cellulose 95 mg (Consolidated Midland Corp.) was given to half of the infants. Tablets were prepared by the hospital pharmacy and were given to the infants by the nursery personnel for 2-4 days and then by the mothers at home. The tablets were crushed into a powder by the mother, mixed with milk and given with a spoon or dropper during a feeding. The mothers understood that this was a double blind study.

## Results

Table 1 shows the feedings which were given to the infants in the two groups. There were no significant differences in the feedings in these groups. Table 2 presents data on growth, thrush, and diaper rash.

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Dr. Collipp specializes in pediatrics and endocrinology. Send reprint request to him at 176 Memorial Dr., Jesup, GA 31545. Mead Johnson, Inc., provided financial support for this study.

**TABLE 1 — Infants Receiving Zinc Supplements and Placebos, by Kind of Feedings, 1-Year Study, Jesup**

<i>Kind of Feeding</i>	<i>Zinc Supplemented (89)</i>	<i>Placebo (90)</i>
Breast	33	25
Enfamil	26	22
Similac	15	26
ProSobee	13	7
Isomil	1	7
Nursoy	1	3
<b>TOTAL</b>	<b>89</b>	<b>90</b>

There was no significant difference in birth weight. The average infant that received oral zinc supplements gained more height (0.39 cm) and weight (126 grams) than the average placebo infant, although the differences were not statistically significant. There was a remarkable and significant reduction in the incidence of diaper rash in the zinc supplemented group 13 of 89 infants, compared to 31 of 90 infants in placebo group). A small reduction in the incidence of oral thrush was also found in the zinc supplemented group, but the difference was not statistically significant.

#### Discussion

Our previous report<sup>6</sup> indicated that the mean hair zinc concentra-

tion (204 µg/gm) in 308 normal newborn infants fell to 110 µg/gm at age 4 months and rose again to 144 µg/gm by age 12 months. The levels were higher in breast-fed infants than in formula-fed infants. This decline in hair zinc concentration during the first year has been reported also by others; serum levels also decline similarly.<sup>1-6</sup>

Oral zinc supplements were found in this study to result in a small but not significant increase in height and weight. The previous study<sup>8</sup> resulted in the zinc concentration of infant formula being raised to a level similar to that found in human milk, (5.1 mg/L). The present study which provided an additional 10 mg per day for the first 4 months of life, suggests that a

slightly higher concentration of zinc might be worthy of consideration. This seems quite reasonable in light of the fact that zinc levels fall during the 6 months in the serum and hair of formula-fed infants when they receive the 5.1 mg/L in their formula. Zinc supplements could be made available in infant vitamin drops as an alternative. Additional zinc in the infant formula, or in the vitamins which babies receive, would be the least expensive and simplest way to provide them with more zinc.

We had reported<sup>9</sup> a hair zinc concentration of 125µg/gm in 56 in-

**Human breast milk contains a zinc binding ligand which improves zinc intestinal absorption, but infant formula is iron fortified which will reduce zinc absorption.**

fants with diaper rash, and 151.9µg/gm in 63 infants with no diaper rash ( $P<0.02$ ) when they were examined during the first year of life.

**TABLE 2 — Incidence of Growth, Oral Thrush, and Diaper Rash among Breast- and Formula-Fed Infants, 1-Year Study, Jesup**

	<i>All<sup>c</sup></i>	<i>Breast</i>	<i>Emfamil</i>	<i>Similac</i>	<i>ProSobee</i>
<b>Weight Gain (cm)</b>					
Placebo	14.07(90)	13.89(25)	14.08(22)	14.14(26)	14.88(7)
Zinc	14.46(89)	14.03(33)	14.48(26)	14.52(15)	15.00(13)
P <sup>a</sup>	ns	ns	ns	ns	ns
<b>Weight Gain (gm)</b>					
Placebo	3209(90)	3052(25)	3387(22)	3186(26)	2896(7)
Zinc	3335(89)	3333(33)	3180(26)	3458(15)	3415(13)
P <sup>a</sup>	ns	ns	ns	ns	ns
<b>Diaper Rash (#)</b>					
Placebo	31(90)	10(25)	3(22)	14(26)	2(7)
Zinc	13(89)	3(33)	5(26)	1(15)	3(13)
P <sup>b</sup>	0.002	0.005	ns	0.002	ns
<b>Oral Thrush (#)</b>					
Placebo	40(90)	9(25)	11(22)	15(26)	3(7)
Zinc	32(89)	12(33)	12(26)	4(15)	3(13)
P <sup>b</sup>	ns	ns	ns	0.055	ns

<sup>a</sup> chi square analysis

<sup>b</sup> student's t test

<sup>c</sup> 8 children received Isomil and 4 received Nursoy (too few for separate analysis) number of infants in each group

m centimeter

gm gram

ns not significant probability



Therefore, diaper rash was associated with lower hair zinc concentrations.

Diaper rash can be influenced by a variety of factors including host defense, frequency of diaper changes, composition and design of diapers, frequency and composition of urine and stools. The irritant or chafing diaper rash can result from the effect of mixing urine and stool, which raises the pH, and activates irritating lipases and proteases.<sup>10</sup> Atopic dermatitis and seborrheic dermatitis may include rash in the diaper area, but they are usually diagnosed by rash elsewhere on the body as well. *Candida albicans* diaper dermatitis usually lasts longer than 3 days, and there is intense confluent erythema, with a sharp border, and some satellite papules beyond the border.<sup>11</sup> They may or may not have oral thrush. Zinc oxide ointment has often been prescribed for infants with diaper rash, and the present study suggested that oral zinc supplements will prevent it in many infants.

### Summary

A total of 89 normal newborn infants received 10mg oral zinc supplements daily for 4 months and 90 others received a placebo. The zinc supplemented group had a significant reduction in the incidence of diaper rash, and they gained slightly more in height and weight, although the growth differences were not significant.

### Diaper rash was associated with lower hair zinc concentrations.

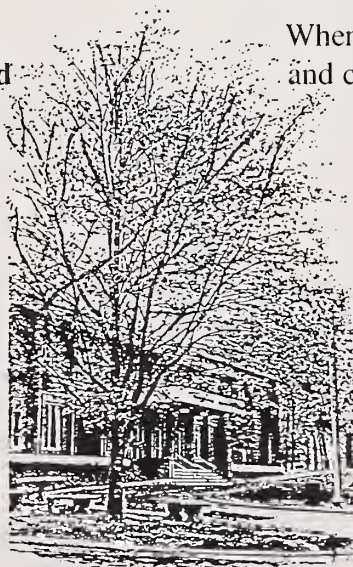
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# Methotrexate Pneumonitis: A Case Report and Summary of the Literature

Stephen H. Hand, M.D., James K. Smith, M.D., Bashir A. Chaudhary, M.D.

## Introduction

**M**ETHOTREXATE is a clinically important anti-neoplastic and immunosuppressive agent. Since its introduction some 40 years ago, it has become a mainstay in the treatment of many common malignancies of the breast, ovaries, bladder, and head and neck. Non-Hodgkins lymphomas, some sarcomas and choriocarcinoma also benefit from methotrexate therapy, as do certain non-neoplastic diseases including generalized psoriasis and selected cases of refractory rheumatoid arthritis.<sup>1,2</sup>

Pulmonary toxicity occurs in a small but significant percentage of patients receiving methotrexate. If

## Abstract

**Methotrexate is used to treat a growing number of malignancies, severe rheumatoid arthritis, and refractory psoriatic arthritis. Pneumonitis induced by the drug occurs in a small percentage of patients and is usually associated with fever, cough, dyspnea, and restrictive pulmonary disease. Severe reactions may progress to respiratory failure. Early recognition of the toxicity is important, and discontinuation of the drug and therapy with corticosteroids usually lead to dramatic improvement.**

not recognized and treated early, such toxicity may result in severe restrictive pulmonary disease and respiratory failure.<sup>3</sup> Even when suspected, the diagnosis of methotrexate pneumonitis may be difficult to confirm and easily confused with

pulmonary infection. Because of the extensive and ever increasing clinical use of this drug, it is important for the practicing physician to be aware of its potential pulmonary toxicity. Herein, we report a case of methotrexate pneumonitis and discuss the clinical, radiographic, and pathologic features of this disorder.

## Case Report

A well nourished, 74-year-old man was admitted with a 5-day history of progressive dyspnea, non-productive cough, fever, and chills. Five years previously he was diagnosed as having adenocarcinoma of the prostate by transurethral

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prostatectomy. He received prostatic and pelvic irradiation, bilateral orchiectomy, and lumbosacral irradiation. Seven months prior to admission, oral chemotherapy was begun for widespread bony metastases demonstrated by bone scan. At the time of admission, the patient was receiving methotrexate 10mg twice a week (total dose 500 mg), melphalan 2mg daily, and prednisone 10mg daily. The patient admitted to a long history of smoking but denied risk factors for the acquired immunodeficiency syndrome.

Examination revealed the patient to be anxious and in mild respiratory distress. The respiratory rate was 30 breaths/min.; the pulse 72 beats/min.; the blood pressure 122/65mmHg; the oral temperature 38.1C. Chest examination was normal, and there was no evidence of

heart failure or peripheral lymphadenopathy. Except for an enlarged and hard prostate, the remainder of the physical examination was unremarkable. Arterial blood gas analysis with the patient breathing room air showed pH 7.47; PO<sub>2</sub> 46mmHg; and PCO<sub>2</sub> 30 mmHg. The peripheral blood leukocyte count was 3,500 cells/m<sup>3</sup> with 73% polymorphonuclear leukocytes, 5% bands, 12% lymphocytes, 9% monocytes, and 1% basophils. Platelet count, hemoglobin, coagulation studies, and electrolytes were normal. Chest roentgenogram revealed diffuse bilateral reticular and nodular infiltrates (Figure 1).

Following admission to the hospital, the patient's respiratory status deteriorated, and he continued to have daily fever as high as 39.4C. Fiberoptic bronchoscopy showed normal airway anatomy. Trans-

bronchial biopsies revealed interstitial mononuclear cell infiltrate, areas of interstitial fibrosis, and poorly formed, noncaseating, granulomas (Figure 2). Special stains were negative for bacteria, fungi, and protozoa.

The diagnosis of methotrexate pneumonitis was made and the patient was started on methylprednisolone, 120mg intravenously every 6 hours. Over a 96-hour period, the patient's gas exchange and clinical condition markedly improved. Roentgenographic abnormalities slowly resolved over the next 3 months (Figure 3).

### Discussion

Pulmonary injury, distinct from infection, was first described as a complication of methotrexate ther-

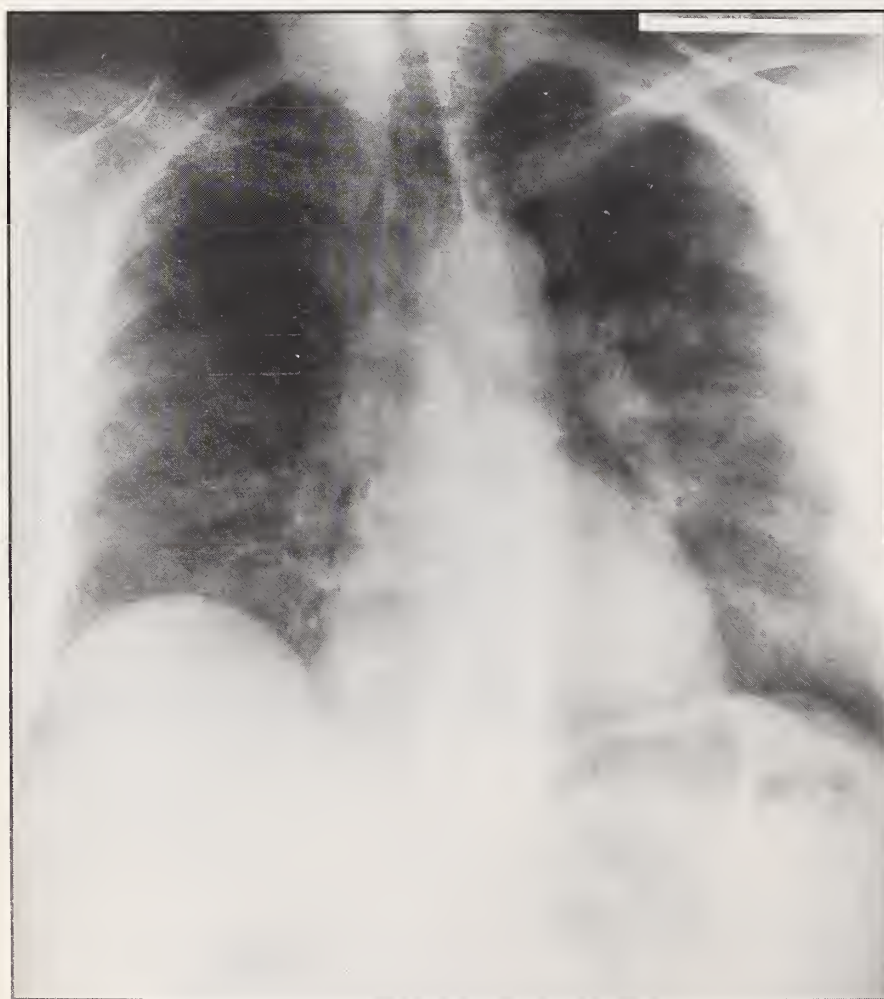


Figure 1 — Admission chest roentgenogram showing bilateral interstitial and alveolar infiltrates predominantly in the bases.

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**Perhaps more problematic from a diagnostic standpoint is the fact that toxicity can begin within days of the first dose, or as in our patient, after months or even years of receiving medication.**

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apy in 1969.<sup>4</sup> To date, over 50 cases have been reported in patients receiving methotrexate for a variety of malignant and nonmalignant disorders. Despite widespread use of methotrexate, pulmonary injury is a relatively uncommon complication. One retrospective study identified seven patients with methotrexate-induced pulmonary disease out of 96 patients receiving the drug.<sup>5</sup> Neither dose nor route of delivery appear to predict disease. Pneumonitis, while appearing to be rare in those patients receiving less than 20mg of methotrexate per week, has been demonstrated following as little as 7.5mg per week in patients treated for rheumatoid



arthritis.<sup>1,2</sup> Perhaps more problematic from a diagnostic standpoint is the fact that toxicity can begin within days of the first dose, or as in our patient, after months or even years of receiving medication.

Symptoms of methotrexate pneumonitis include fever, chills, non-productive cough, dyspnea, and headache. Typically, constitutional symptoms precede pulmonary symptoms by a week or more; however, the clinical presentation may vary considerably. Acute respiratory failure, necessitating mechanical ventilatory support, may dominate the clinical picture, and a rapidly fatal illness has been described.<sup>3,6</sup> Often methotrexate pneumonitis is initially diagnosed as a viral respiratory tract infection.

Clinical complaints may precede radiographic changes by a week or more, but essentially all patients will manifest radiographic abnormalities at some time during their course. The most common manifestation is a diffuse interstitial or mixed interstitial and alveolar infiltrate occupying the mid to lower lung fields.<sup>7,8</sup> Small pleural effusions, hilar adenopathy, and focal infiltrates occur infrequently.<sup>7</sup>

Laboratory abnormalities include hypoxemia and hypocapnia in virtually all cases. Eosinophilia occurs in approximately 40% of cases and when present is an important clue to the diagnosis. A reduced carbon monoxide diffusing capacity and restrictive impairment to ventilation have been described, but neither abnormality is specific for this disorder.<sup>3</sup> Lung biopsy findings include alveolar cell atypia, widespread interstitial mononuclear infiltrate, and fibrosis. Well organized granulomas can be seen in selected cases.

The pathogenesis of methotrexate pneumonitis is yet to be fully defined. Insight into the disorder is hampered by a relative sparsity of clinical material and the lack of an appropriate animal model. Existing hypotheses are that methotrexate damages the lung via a cytotoxic effect or initiates a drug-related hypersensitivity reaction. Certain clinical observations including an association with fever and eo-

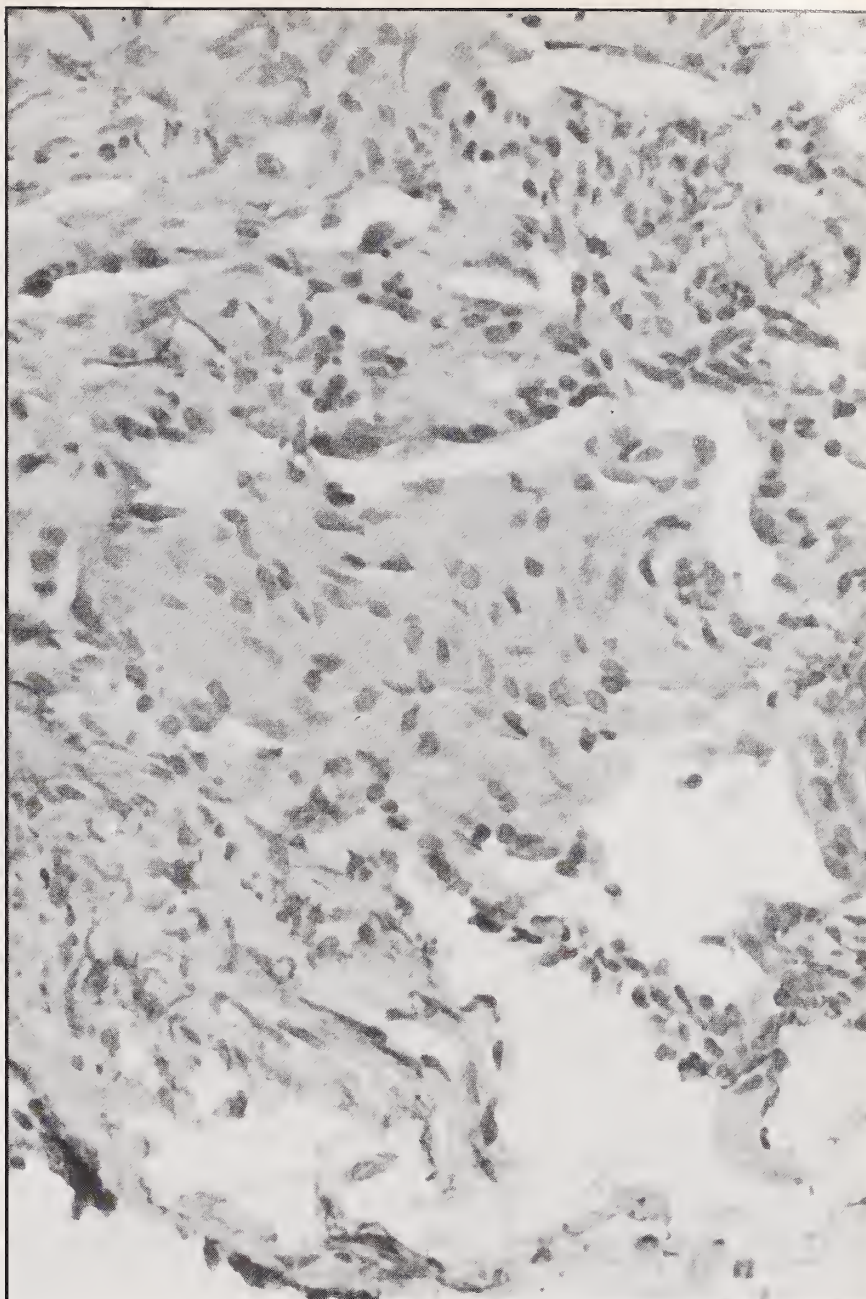


Figure 2 — Photomicrograph of transbronchial lung biopsy revealing interstitial fibrosis, mononuclear cell infiltration, and noncaseating granulomas.

sinophilia and an absent dose-effect relationship suggest the mechanism is that of hypersensitivity. A recent study implicating cell mediated immunity in the pathogenesis is also consistent with this hypothesis.<sup>9</sup> Still, the clinical and histologic presentation can vary considerably from patient to patient, and it is not inconceivable that methotrexate may damage the lung by more than one mechanism. Obviously, large gaps in our understanding of methotrexate pneumonitis remain to be elucidated by

further clinical and laboratory investigation.

Lacking specific clinical features, the diagnosis of methotrexate pneumonitis rests on a high degree of clinical suspicion and exclusion of other causes of pulmonary disease. Lung tissue obtained via transbronchial biopsy or by open lung biopsy is extremely helpful in providing supporting histologic evidence and ruling out infection. Specimens should be examined for routine bacteria, *Legionella* species, *Mycoplasma*



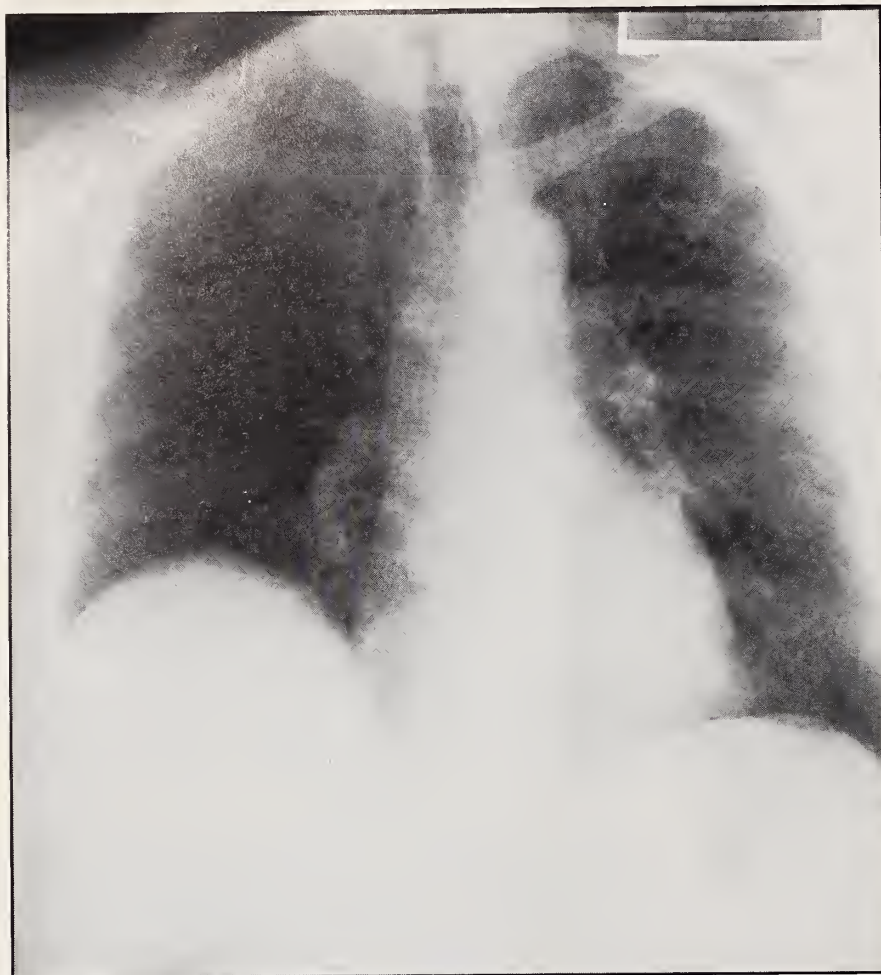


Figure 3 — Follow-up chest roentgenogram taken 3 months later which reveals clearing of the infiltrates.

species, acid fast organisms, fungi, and *Pneumocystis carinii*.

Treatment of methotrexate pneumonitis centers around supporting the patient's ventilation and discontinuing the antimetabolite. In more severe cases complicated by hypoxemia, such as in our patient, corticosteroids may dramatically improve symptomatology and hasten recovery.<sup>3, 10</sup> Fortunately, the outcome of methotrexate pneumonitis is usually favorable. Mortality has been estimated at 1%, and

survivors infrequently manifest permanent pulmonary impairment.<sup>3, 5</sup>

**I**n summary, we have presented a case of severe methotrexate pneumonitis with many of the clinical, radiographic, and pathologic features characterizing this disorder. The diagnosis was based on a strong clinical suspicion and supported by typical pathologic findings. Widespread use of methotrexate in the fields of oncology and clinical immunology has made it

**Widespread use of methotrexate in the fields on oncology and clinical immunology has made it increasingly likely that this complication will be encountered in clinical practice.**

increasingly likely that this complication will be encountered in clinical practice. This drug-induced pulmonary disease should be carefully considered in all patients presenting with fever, dyspnea, and pulmonary infiltrates who have received methotrexate.

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# Dietary Fluoride Supplements for Children — The Role of the Physician

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## Introduction

**T**HE APPROPRIATE USE of fluoride remains the best defense against dental caries. This is true despite extensive efforts to develop improved methods of mechanical plaque removal, to develop chemica agents that safely and effectively reduce the cariogenic acitivity of bacteria, and to reduce the frequency of intake of cariogenic foods by modification of dietary practices.<sup>1</sup> Pit-and-fissure sealants are an important weapon in caries control,<sup>2</sup> but their full impact depends heavily on the ability of fluorides to control smooth surface caries. Although the mechanisms by which fluorides exert their caries-inhibiting effects are not fully understood, they are thought to include:

- (1) Reduction of enamel solubility;
  - (2) Remineralization of early carious lesions; and
  - (3) Action on plaque bacteria.
- There has been greater interest in

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**Children who drink water from an optimally fluoridated community system or a school fluoridation system should not receive systemic fluoride supplements.**

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and understanding of the remineralization process in recent years, showing that many early carious lesions may be reversible if treated promptly and properly with fluoride.

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Fluoride products are intended for use either systemically or topically. Systemic fluoride is ingested, absorbed, and incorporated into developing bone and tooth structure. In contrast, topical fluorides work only locally on superficial layers of enamel and on plaque. Methods of delivering systemic fluorides in the United States include community water fluoridation, school water fluoridation, and dietary fluoride supplements. Topical fluorides may be applied professionally or self-applied. They include fluoride solutions and gels (applied in trays or with a toothbrush or applicator), fluoride dentifrices, and fluoride mouth rinses. Topical benefits also result from drinking fluoridated water or from chewing fluoride tablets.

Discussions on these methods of delivering fluorides are contained in a special section in the September, 1986, issue of *JADA*, entitled "A Guide to the Use of Fluorides for

the Prevention of Dental Caries,"<sup>3</sup> and in the American Dental Association's *Accepted Dental Therapeutics*.<sup>4</sup> A comprehensive fluoride program should include a systemic form and may include one or more topical forms. The systemic and topical modes should not be used in lieu of each other but should complement each other.

Several studies have found that the majority of physicians and dentists reported prescribing dietary fluoride supplements for some of their child patients.<sup>5-9</sup> Studies also have shown, however, that some practitioners are unaware of the proper supplement protocol (including water fluoride testing, when necessary), dosage guidelines, and the actual fluoride concentrations in the area's main water supplies.<sup>5-11</sup>

The purposes of this paper are to explain the need for and the importance of dietary fluoride supplements in Georgia, and to review the proper protocol for their use. The article should help the practitioner provide optimum preventive care to young patients.

#### **The Need for Systemic Supplements**

Community water fluoridation is the most efficient and cost effective method of providing systemic fluoride for the prevention of dental caries.<sup>12</sup> Unfortunately, almost one-half of the population of the United States drinks water that is not optimally fluoridated.<sup>13</sup> Georgia is most fortunate in having a mandated fluoridation law since 1973. Approximately 96% of the population served by community water systems is receiving fluoridated water. However, this figure represents only 76% of Georgia's total population. In fact, even if *all* community water systems were fluoridated, 20% of the state's population would remain without access to fluoridated water.

Alternative sources of systemic fluoride are necessary if more children are to be provided the caries preventive benefits of systemic fluoride. School water fluoridation is one alternative but is not presently being used in Georgia. Gen-

erally, the water from school fluoridators contains 4.5 times the optimal level of fluoride for community water fluoridation in that particular geographic area to approximate the fluoride intake that would take place if the children were drinking water fluoridated at the average optimal 1.0 ppm all day, every day. The students drink the school water only for a few hours on school days (approximately 180 days per year). Children who drink school water fluoridated at 4.5 times optimal will experience substantial caries reductions up to 40%. The benefits are particularly great in the late forming teeth which receive

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**Because there can be significant variations in water fluoride content from nearby wells, even in a small geographic area, one should not rely on the results of a sample from a different source, no matter how near.**

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both systemic and topical exposure.<sup>14</sup>

Children who drink water from an optimally fluoridated community system or a school fluoridation system *should not receive systemic fluoride supplements*. Specific information about the concentration of fluoride in your community's water supply may be obtained from your local water company, health department, or dental public health personnel. Dr. E. Joseph Alderman, Director of the Office of Dental Health, Division of Public Health, Georgia Department of Human Resources, can provide lists of communities in Georgia that are optimally fluoridated.

#### **Fluoride Supplements**

For children who do not receive fluoridated water, the use of dietary

fluoride supplements (tablets or drops) is a safe and effective means of reducing the incidence of dental caries by up to 60% or more<sup>15-22</sup> and has been recommended for use in private practices.<sup>23</sup> In order to receive maximum preventive benefits, the supplements must be taken daily from birth until at least age 13.<sup>4</sup>

#### **Supplement Protocol**

It is important that children receive the appropriate dose of systemic fluoride. This can be accomplished only if the practitioner knows the fluoride concentration of the patient's main source of drinking water. Occasionally, more than one important patient water source must be considered and the average fluoride level determined. Fluoride levels exceeding the optimal are associated with an increased risk of dental fluorosis (mottling).<sup>24</sup> Although fluorosis is primarily a cosmetic problem, severe cases often involve pitting of the tooth surface. Therefore, to avoid exceeding the recommended dose, the practitioner should know which communities in the area are fluoridated and the concentration of fluoride.

A separate water sample should be submitted in order to determine the fluoride content of a patient's community, school, or individual water supply if the practitioner does not have prior specific knowledge of the level. Because there can be significant variations in water fluoride content from nearby wells, even in a small geographic area, one should not rely on the results of a sample from a different source, no matter how near.

#### **Water Sampling Procedures**

The Medical College of Georgia, Department of Oral Biology, will analyze patient's water samples for health professionals for a \$5 fee. Water sample bottles and further details about the program can be obtained by contacting: Gary Whitford, Ph.D., D.M.D., Department of Oral Biology, Medical College of Georgia, Augusta, GA 30912; 1-800-222-6005, Ext. 2034.



## Dosage Schedule

The present guidelines for systemic fluoride supplements recommended by the American Dental Association, the American Academy of Pediatric Dentistry, and the American Academy of Pediatrics are shown in Table 1.<sup>4, 25-27</sup> Any water fluoride level greater than 0.3 ppm requires adjustment from the full dosage supplement.

formula now receives fluoride almost exclusively from the water which may be mixed with the formula.<sup>29</sup> The practitioner must determine the proportion of bottle-feeding and reduce the supplement accordingly for those infants receiving nutrition from both sources.

Since excessive fluoride can cause fluorosis, parents should contact the provider of the supple-

sonnel in order to facilitate the process.<sup>9</sup>

Fluoride tablets are now available in 0.25, 0.5 and 1.0 mg fluoride formulations. There are several commercial brands available.<sup>3</sup> (See also List of Accepted Products — Fluoride Supplements in the February, 1988, issue of *JADA*.) Additionally, many pharmacies can provide a generic product. The tablet should be chewed before swallowing to provide topical benefit. Fluoride drops, often providing 0.125 mg or 0.25 mg of fluoride per drop, should be used for those who cannot chew a tablet. No more than 264 mg sodium fluoride, or 120 mg fluoride, should be prescribed at one time for safety reasons.<sup>4</sup> The product should be kept in a "child-proof" container in a secure place. Sample prescriptions are shown below for 0.5 mg fluoride dosage tablets and 0.25 mg fluoride dosage drops.

The biggest difficulty with fluoride supplements is patient compliance.<sup>18-21, 30</sup> Numerous studies have documented the effectiveness of fluoride supplements in reducing dental caries. However, the supplementation schedule must be followed conscientiously. These studies have shown that the greatest caries reductions have occurred as a result of select populations seeking pediatric medical or dental care on a regular basis, and also as a result of follow up from dedicated and enthusiastic physicians and dentists who were able to motivate the patients to comply with the dosage regimen. Therefore, the physician must routinely encourage and attempt to monitor the child's supplement use.

## Conclusion

It is hoped that this article will encourage and assist physicians in Georgia in providing appropriate doses of systemic fluoride supplements to those children in need. The medical profession must work closely with dentists and other health professionals if systemic fluorides are to be used to greatest benefit by our population.

**TABLE 1 — Supplemental Fluoride Dosage Schedule,\*  
In mg. of Fluoride Per Day**

Age of Child	Parts per Million Fluoride in Water Supply		
	<0.3	0.3 to 0.7	>0.7
Birth to 2 yrs.†	0.25	0	0
2 to 3 yrs	0.50	0.25	0
3 to 13 yrs.†	1.00	0.50	0

\*Recommended by the Council on Dental Therapeutics of the American Dental Association, by the Committee on Nutrition of the American Academy of Pediatrics, and by the American Academy of Pediatric Dentistry.

†The American Academy of Pediatrics recommends providing supplements from 2 weeks through at least age 16.

## Determination of Appropriate Dosage

After determining the fluoride level of a patient's main source of drinking water (either by submitting samples or obtaining information from water companies, schools, Georgia Department of Human Resources, etc.), the practitioner must determine the appropriate supplement dosage, if any, to prescribe. For example, a 4 year old with a water fluoride level of 0.5 ppm would receive a 0.50 mg supplement instead of the "full" supplement dosage of 1.00 mg appropriate were the water fluoride level to be 0.2 ppm.

It is essential to determine whether an infant is being exclusively breast fed, or bottle fed, or obtaining nutrition from both sources. Totally breast-fed babies should be supplemented fully, since there are very low amounts of fluoride found in human milk, even when the mother resides in a fluoridated area.<sup>28</sup> The major manufacturers of milk-based infant formulas have removed fluoride from their products which previously contained variable levels.<sup>29</sup> An infant on milk-based

ment (physician or dentist) when changes occur in the infant's consumption of liquids so the fluoride supplementation can be adjusted. Significant changes in feeding patterns, such as from breast feeding to bottle feeding or breast feeding to solid foods, must be reported to the provider so that the dosage of fluoride supplements can be adjusted, if necessary.

Although children should see the dentist at a young age, most children do not see a dentist before age 3. The complexities of controlling fluoride dosage for infants and younger children must, therefore, be the joint responsibility of physicians and dentists. It is important to remember that dosage typically must be adjusted at ages 2 and 3.

Determination of water fluoride levels and systemic fluoride needs may be best accomplished as routine parts of new and recall patient examination procedures for pregnant women and children under age 16. Consequently, it has been suggested that physicians and dentists delegate appropriate aspects of these responsibilities to nurses, dental hygienists, and other per-



**Rx Sodium Fluoride Drops\*\***

0.25 mg F/drop

Dispense: 24 ml

Sig: Place one drop daily inside mouth or add to water, formula, or foods.

CAUTION: KEEP OUT OF REACH OF CHILDREN

**Rx Sodium Fluoride Tablets\*\*\***

1.1 mg (0.5 mg F)

Dispense: 120 tabs

Sig: Chew one tablet daily before bedtime, swish for 60 seconds, and swallow.

CAUTION: KEEP OUT OF REACH OF CHILDREN

\*\*Note: This is a generic prescription for fluoride drops to be used when 0.25 mg fluoride is needed, i.e. from birth to 2 years with drinking water containing less than 0.3 ppm fluoride.

\*\*\*Note: This is a generic prescription for fluoride tablets to be used when 0.5 mg. fluoride is needed, i.e. for a 2-year-old with drinking water containing less than 0.3 ppm fluoride or a child aged 3 to 13 with water fluoride content between 0.3 and 0.7 ppm.

**This article should help the practitioner provide optimum preventive care to young patients.**

**Summary**

1. All children should receive one form of systemic fluoride and appropriate forms of topical fluoride.

2. If a child is not receiving optimally fluoridated water, the dentist or physician should prescribe dietary fluoride supplements (tablets or drops).

3. The correct dosage must be determined based on patient age and fluoride content of the patient's main water source(s).

4. Special attention is necessary concerning fluoride intake for children breast feeding or consuming infant formula.

5. To arrive at the correct fluoride dose, these steps should be followed:

- A. *Always* have a sample of the main drinking water source (usually home water) analyzed for the fluoride content before prescribing a fluoride supplement, if you do not have other specific knowledge of water fluoride content. The Medical College of Georgia

(Department of Oral Biology — Dr. Whitford) provides water fluoride assay services.

B. When the fluoride content of the water has been determined, the fluoride level and the child's age should be matched on Table 1 to arrive at the correct supplement dose.

6. Dr. Alderman, Director of the Office of Dental Health, Division of Public Health, Georgia Department of Human Resources, can provide lists of communities in Georgia that are optimally fluoridated.

**Special attention is necessary concerning fluoride intake for infants breast feeding or consuming formula.**

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## *The Supreme Court's Ruling in the Webster Case: Implications for Georgia Physicians*

Andrea L. Harris

### Introduction

**I**N *Webster v. Reproductive Health Services*,<sup>1</sup> a decision announced on the last day of its 1989 term, a deeply divided United States Supreme Court upheld Missouri's controversial statutes restricting abortion procedures. Chief Justice Rehnquist, together with Justices White, Kennedy, Scalia, and O'Connor formed the majority in this 5-4 decision upholding the Missouri laws banning the use of public funds and public facilities in all non-therapeutic abortions. The Court further upheld the constitutionality of the Missouri statute requiring a physician to ascertain fetal viability before performing an abortion on a woman who is 20 or more weeks pregnant. Although these statutory restrictions are currently law only in Missouri, the full impact of the Court's ruling will soon be felt throughout the United States. It is foreseeable that many states, including Georgia, will attempt to introduce legislation encompassing some or all of the restrictions contained in the Missouri laws. Many may go further and introduce even greater restrictions. With this decision, the Court has returned to the states much of the authority to regulate abortions.

In the 1973 landmark decision of *Roe v. Wade*,<sup>2</sup> the Supreme Court held that a Texas statute

criminalizing all non-therapeutic abortions unconstitutionally intruded upon the right of a woman to have an abortion. In *Webster*, the Court, although suggesting it was not overturning the *Roe* decision, appears to have chipped away a major portion of *Roe*'s foundation. In this month's Legal Page, we examine the Court's holding in *Webster* and discuss the implications for Georgia.

### Adoption of State Theory of When Life Begins

Missouri's restrictive abortion statutes have a preamble that attempts to define when life begins. This preamble states that "[t]he life of each human being begins at conception," and that "unborn children have protectable interests in life, health, and well-being." The preamble further provides that all State laws should be interpreted to give unborn children the same rights as those enjoyed by other citizens of Missouri.<sup>3</sup>

The plaintiffs (consisting of five health care professionals employed by the State of Missouri, as well as two nonprofit corporations) challenged this statutory definition, claiming that

it violated the constitutional tenet that "a state may not adopt one theory of when life begins to justify its regulation of abortions."<sup>4</sup> The Court chose not to decide the constitutionality of the preamble, however, since, by its terms, it did not regulate abortions or any aspect of the medical field. In Chief Justice Rehnquist's view, the preamble merely expressed the state's value judgment favoring childbirth over abortion. He stated that if the preamble were used to interpret other state statutes and regulations, affected persons might then bring an action testing the preamble's language in the courts.

**J**ustice Blackmun strongly disagreed in his dissenting opinion, stating that the preamble cannot, realistically, be interpreted as abortion-neutral. In the dissent's view, the Missouri legislature, in fact, did set forth a theory of life, and abortion restrictions will be interpreted with this theory in mind. Justices Blackmun and Stevens also dissented from this portion of the majority's opinion, expressing concern with the scope of the preamble, which defines fetal life as beginning upon "the fertilization of the ovum of a female by the sperm of a male." Under the standard medical definition, conception occurs with the implantation of the ovum in

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the uterus, about 6 days after fertilization. The distinction was critical to the dissenters, in that the use of post-fertilization contraception, such as the IUD and the "morning-after pill," theoretically could violate the Missouri preamble, since these methods would result in the "killing" of the fetal life.<sup>5</sup> The majority of the Court, however, chose to postpone judgment on this issue until the Missouri legislature construes the preamble to infringe upon a woman's right to use post-fertilization contraception.

#### Prohibition on Use of Public Funds or Employees

The Court next upheld the portion of the Missouri Statutes making it unlawful for any public employee, within the scope of his or her employment, to perform or assist any abortion not necessary to save the woman's life<sup>6</sup> and for any public facility to be used for the purpose of performing or assisting these non-therapeutic abortions.<sup>7</sup> The Court asserted that a state has the right to favor childbirth over abortion by its allocation of public funds and public resources, including public hospitals and medical staffs. According to the Court, these statutes did not violate the holding in *Roe* or the Court's subsequent abortion decisions<sup>8</sup> because the statutes did not restrict a woman's access to an abortion. Chief Justice Rehnquist justified this view by explaining that "Missouri's refusal to allow public employees to perform abortions in public hospitals leaves a pregnant woman with the same choices as if the state had chosen not to operate any public hospitals at all."<sup>9</sup> In the majority's view, a woman's right to an abortion is only restricted if she

***“By using public water, sewage lines, or state-owned equipment or by leasing land owned by the state, for example, a private hospital might be deemed to be “public” and thus fall within the scope of these statutes.”***

chooses to use a physician affiliated with a public hospital. There is nothing in the Constitution requiring the states to be in the abortion business or entitling private physicians and their patients access to public facilities for the performance of abortions.

**T**he dissenting Justices criticized this view on several fronts, including the ramifications of Missouri's definition of "public." Under these statutes, a public facility is "any public institution, public facility, public equipment, or any physical asset owned, leased, or controlled by this state or any agency or political subdivision thereof."<sup>10</sup> With such a sweeping definition of public facilities, a pregnant woman could be left with far fewer choices of abortion facilities. By using public water, sewage lines, or state-owned equipment or by leasing land owned by the state, for example, a private hospital might be deemed to be "public" and thus fall within the scope of these statutes.

#### Physician Determination of Viability

In perhaps the most publicized aspect of its opinion, a majority of the Court also upheld the Missouri statute requiring a physician, before performing an abortion on a woman he or she believes is carrying an unborn child of 20 or more weeks gestational age, to determine if this unborn child is viable by using that degree of care, skill, and proficiency that is commonly exercised by the practitioners in the field. This statutory provision further required that, in making this viability determination, the physician shall perform such medical examinations and tests as are necessary to determine the unborn child's gestational age, weight, and lung maturity.<sup>11</sup> The Court interpreted this last sentence as not requiring the physician, *in every case*, to perform these tests. Instead, the physician should perform only those tests that are useful in making subsidiary viability findings. According to the Court, the physician must use his or her reasonable professional skill and judgment in deciding to perform the tests, and those tests that would be irrelevant to determining viability or harmful to the mother and the fetus would not be required and should not be performed.

Under the majority's analysis, this Missouri statute was constitutional since it permissibly furthered the state's interest in protecting potential human life. The Missouri legislature had chosen viability as the point at which the state's interest in potential life must be safeguarded. By doing this, the legislature has created a presumption of viability at 20 weeks, which the physician must



**‘The Missouri legislature has created a presumption of viability at 20 weeks, which the physician must rebut by performing certain required tests and proving that the fetus is not viable.’**

rebut by performing certain required tests and proving that the fetus is not viable.

In *Roe*, the Court had held that the right to personal privacy implied in the Constitution covered a woman's right to have a qualified abortion. During the first trimester, a state has no interest in a fetus compelling enough to restrict abortions, while in the second trimester, the state may choose to regulate the abortion procedure in a way that is reasonably related to maternal health. Under *Roe*, a state could prevent all abortions during the last trimester. Four justices in *Webster*, however, would now depart from this standard; according to this plurality, *Roe*'s rigid trimester analysis is now "unsound in principle and unworkable in practice."<sup>12</sup>

Evidencing this view, Chief Justice Rehnquist stated that in deciding *Roe*, the Supreme Court created a web of legal rules resembling a code of regulations rather than a body of constitutional doctrine. He believed the regulation of these medical procedures must be returned to the States. Justice Rehnquist found no justification as to why a state's compelling interest in protecting potential human life commences only at

the point of viability rather than extending throughout the entire pregnancy. He would, therefore, abandon *Roe*'s trimester framework and allow each individual state to regulate abortion procedures within its borders.

Justice Blackmun (the author of the *Roe* decision) vehemently opposed the Court's attempt to abandon the trimester approach of *Roe*. He maintained that Missouri's viability testing statute, as interpreted by the Court, is consistent with the *Roe* framework "and could be upheld effortlessly under current doctrine." Justice Blackmun remained satisfied that "the *Roe* framework, and the viability standard, in particular, fairly, sensibly, and effectively functions to safeguard the constitutional liberties of pregnant women while recognizing and accommodating the state's interest in potential human life."

Under the Court's interpretation of Missouri's viability testing statute, a physician is required to conduct tests that in his or her discretion would determine viability. This "requirement" may prove difficult for physicians since the tests must be made only when it is feasible and medically appropriate. With this interpretation, questions may arise as to whether the viability of tests are mandatory or merely supplemental. Instead of providing guidance, the Court may actually have increased the uncertainty.

#### **Implications for Georgia**

The Court's decision in *Webster*, while not explicitly overturning *Roe v. Wade*, represents a significant departure from the once settled constitutional principle

guaranteeing women a right to an abortion in the first two trimesters of pregnancy. By upholding the Missouri statutes that regulate abortion procedures, the Supreme Court would seem to be ushering the states back into the abortion legislation arena. In the view of Justice Blackmun:

A plurality of this Court implicitly invites every state legislature to enact more and more restrictive abortion regulations in order to provoke more and more test cases, in the hope that some time down the line the Court will return the law of procreative freedom to the severe limitations that generally prevailed in this country before January 22, 1973.<sup>13</sup>

While this may not be the actual intention of the Court, it could be the effect. The immediate reaction in many state legislatures, including, possibly, Georgia's General Assembly, may be to enact laws very similar to these Missouri statutes that have been held constitutional. A few states may even attempt to pass laws further restricting abortions. Many of these statutes will wind up in the courts, being tested under the Constitution and judicial precedent. In fact, the Supreme Court has announced that it will hear arguments next session on three more abortion cases. The Court will decide the constitutionality of statutes requiring parental notification for minors seeking abortions, waiting periods of at least 24 hours before the actual abortion is performed, and private abortion clinics to have the equipment and staff similar to hospitals.

While the battles will continue to be fought in the courtroom, the new battlefield

may well become the physician's office. Were the Georgia legislature to enact laws similar to those adopted in Missouri, Georgia physicians will face confusion and uncertainty. What are these "tests" physicians should perform to determine viability? What facilities are

***‘If the Georgia legislature were to enact laws restricting abortions, physicians may be confronted with ethical questions involving physician-patient confidentiality. For example, will the doctor be forced to give the parental notification before performing an abortion on a minor if the minor refuses to give this required notice?’***

“public” and, therefore, may not be used for performing abortions? What is the standard for

determining the degree of care, skill, and proficiency that is required?

Moreover, if the Georgia legislature were to enact laws restricting abortions, physicians may be confronted with ethical questions involving physician-patient confidentiality. For example, will the doctor be forced to give the parental notification before performing an abortion on a minor if the minor child refuses to give this required notice? There are no answers as of yet to these questions; it is now in the hands of the Georgia legislature and the courts.

#### Notes

1. \_\_\_\_\_ U.S. \_\_\_\_\_, 1989 U.S. LEXIS 3290 (July 3, 1989).
2. *Roe v. Wade*, 410 U.S. 113 (1973).
3. Mo. Rev. Stat. §§1.205.1(1)(2) and 1.205.2 (1986).
4. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 444 (1983); see, also, *Roe v. Wade*, *supra*, 410 U.S. at 159-162.
5. According to Justice Stevens, this potential result would render the preamble unconstitutional, as it would interfere with a woman's choice of contraceptive methods.
6. Mo. Rev. Stat. § 188.210 (1986).
7. Mo. Rev. Stat. § 188.215 (1986).
8. See, e.g., *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); *Calautti v. Franklin*, 439 U.S. 379 (1979).
9. *Webster*, *supra*, \_\_\_\_\_ U.S. at \_\_\_\_\_, 1989 U.S. LEXIS 3290 at page 31.
10. Mo. Rev. Stat. § 188.200(2) (1986).
11. Mo. Rev. Stat. § 188.029 (1986).
12. *Webster*, *supra*, \_\_\_\_\_ U.S. at \_\_\_\_\_, 1989 U.S. LEXIS 3290 at page 47.
13. *Webster*, *supra*, \_\_\_\_\_ U.S. at \_\_\_\_\_, 1989 U.S. LEXIS 3290 at page 79.



## The Treatment of Chronic Hypertension in Children and Adolescents

DeeAnne Sexton, M.D.

### Defining Hypertension in Children

**T**HERE ARE NO STUDIES available defining exact levels of blood pressure in infants, children, and adolescents that are associated with increased risk of hypertension in adult life, coronary heart disease, renal disease, or CVA.<sup>1,3</sup> However, a definition of hypertension must be established in order to decide when therapeutic intervention is necessary. The Second Task Force on Blood Pressure Control in Children<sup>2</sup> approached this problem by developing definitions of hypertension based upon epidemiologic data on normal blood pressure distributions in infants, children, and adolescents, along with clinical experience and the consensus of members of the task force. In their report in *Pediatrics*, Jan. 1987, the following definitions are presented:

*Normal blood pressure* is defined as systolic and diastolic blood pressure below the 90th percentile for age and sex.

*High normal blood pressure* is an average systolic and/or diastolic pressure between the 90th and 95th percentile for age and sex.

*Significant hypertension* is blood pressure which persistently falls between the 95th and 99th percentile for age and sex.

*Severe hypertension* falls

**‘Children with high normal blood pressure should be on a nonpharmacologic antihypertensive regimen, and patients with significant hypertension should receive a trial of nonpharmacologic management of their blood pressure prior to beginning antihypertensive drug therapy.’**

persistently above the 99th percentile for age and sex.

In each case, the child's height and weight must be taken into consideration. Elevated blood pressure in a child who is tall for his or her age or whose lean body mass is increased for sex and age may be considered normal, but elevated blood pressure is not considered normal in a child who is obese.

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This article was prepared at the request of the Georgia Affiliate of the American Heart Association.

### Indications For and Goals of Therapy in the Hypertensive Child

Although the natural history of hypertension beginning in childhood and adolescence is not well defined, it is believed that many of these children will go on to be hypertensive adults.<sup>2,3</sup> Drug therapy has been demonstrated to decrease the number of cardiovascular, renal, and CNS complications in adults with primary hypertension. Although no studies are available to demonstrate the efficacy of therapeutic intervention in preventing complications in children with essential hypertension, it is felt that these children will benefit similarly from antihypertensive therapy.<sup>2</sup> As with any therapeutic intervention, the risks of therapy must be carefully weighed against the proposed benefits before treatment is begun. Therapeutic intervention is aimed at maintaining systolic and diastolic blood pressure below the 90th percentile for age and sex. Optimal antihypertensive therapy maintains blood pressure in the target range using the smallest amount of drug possible, thereby minimizing side effects and simplifying the regimen so as to encourage patient compliance.<sup>1</sup> The indications for therapeutic intervention in hypertensive children and adolescents are shown in Table 1.

**TABLE 1 — Indications of Therapeutic Intervention in Hypertensive Children and Adolescents.<sup>1</sup>**

- Indications for nonpharmacologic therapy
  - Systolic and or diastolic blood pressure  $\geq 90$ th percentile (high normal BP)
- Indications for antihypertensive drug therapy
  - Significant hypertension (diastolic and/or systolic BP  $\geq 95$ th percentile)
  - Severe Hypertension (diastolic and or systolic BP  $\geq 99$ th percentile)
  - Evidence of end organ injury (increased BUN, increased creatinine, proteinuria, cardiomegaly, LVH)
  - Signs and symptoms of elevated blood pressure
- Indication of parenteral therapy
  - Acute, severe hypertension (as seen in acute glomerulonephritis, hemolytic uremic syndrome, and head injuries)

**TABLE 2 — The Stepped-Care Approach to Antihypertensive Therapy in Children and Adolescents<sup>1</sup>**

**STEP 1: Small Dose of Thiazide Diuretic or Adrenergic Inhibitor or ACE Inhibitor**

- Gradually increase dose until target BP is reached or side effects are seen or max drug dosage is reached.
- If BP not controlled, then change to different drug or go to step 2.

**Step 2: Add Small Dose of Thiazide Diuretic or Adrenergic Inhibitor or ACE Inhibitor**

- choose drug with different mechanism of action than that used in step 1.
- Gradually increase dose as in step 1.
- If BP not controlled — LOOK FOR PREVIOUSLY UNDETECTED CAUSE OF SECONDARY HYPERTENSION.
- If not cause found and BP not controlled go to step 3.

**Step 3: Add Small Dose of Vasodilator or one of above**

- Choose drug with different mechanism of action than those used in steps 1 and 2.
- Gradually increase dose as in steps 1 and 2.

**Step Down**

- After blood pressure is well controlled for several months, gradually decrease drug dosage to lowest effective dose.

**Goals of therapy**

- Diastolic BP  $< 90$ th percentile
- Minimal side effects
- Use of lowest effective dose of drug
- High degree of patient compliance

blood pressure as well as between weight loss and decrease in systolic blood pressure in both normotensive and hypertensive patients of all ages.<sup>5</sup> Therefore, obese children with hypertension should be tried on a program of weight reduction prior to the initiation of any pharmacologic therapy.<sup>1</sup>

Aerobic exercise has enjoyed increasing popularity over the past 2 decades and has been shown to decrease blood pressure in hypertensive adults.<sup>6</sup> In 1983, Hagberg, et al<sup>7</sup> demonstrated a significant decrease in both systolic and diastolic blood pressure in 25 adolescents placed on an exercise program consisting of 30 to 40 minutes of aerobic exercise three times per week. Although exercise along has not been demonstrated to decrease blood pressure into the normotensive range, endurance training is a valuable adjunct to other nonpharmacologic measures as well as drug therapy. Participation in sports and other activities by hypertensive children and adolescents should be encouraged except in those with severe hypertension which is poorly controlled. These children should be encouraged to begin an exercise program when their blood pressure is brought under control.

Restriction of dietary sodium intake has been demonstrated to decrease blood pressure in many hypertensive patients, although a consensus has not been reached regarding the degree of sodium restriction necessary to lead to a beneficial effect or the patients who are likely to benefit from a low sodium diet.<sup>1, 6, 8, 9</sup> Recommendations vary from avoidance of "junkfood" and salt added at the table<sup>9</sup> to strict limitation of dietary sodium intake

### Treatment of Hypertension in Pediatric Patients

The first line of therapy for chronic hypertension in children is nonpharmacologic intervention consisting of weight loss, aerobic exercise, and dietary sodium restriction. The direct relationship between obesity and hypertension is well established (obesity is

more common in hypertensive patients, and hypertension is more common among obese individuals).<sup>4, 5</sup> This relationship has been demonstrated beginning in infancy and persisting into adulthood.<sup>5</sup> More importantly, the Framingham study demonstrated a linear relationship between weight gain and rise in systolic



TABLE 3 — Oral Antihypertensive Agents<sup>2</sup>

	Drug	Dosage	Common Side Effects
Diuretic Adrenergic Inhibitors	Hydrochlorothiazide	1-2 mg/kg/24 hr	Hypokalemia
	Prazosin (alpha blocker)	1 mg initial dose may increase to 15 mg/24 hr divided bid-tid	Orthostatic Hypotension
	Propanolol (beta blocker)	.25-1.0 mg/kg/dose 96-12 hr (maximum dose 2 mg/kg/day)	Bronchospasm, Bradycardia
Ace Inhibitor	Captopril	.3 mg/kg/24 hr initially. May increase to maximum dose of 2 mg/kg/(24 hr)	Proteinuria
Vasodilator	Hydralazine	.75 mg/kg/24 hr initially. May increase to maximum dose of 3 mg/kg/24 hr	Drug-induced lupus

to 4 to 6 grams of NaCl per day.<sup>1,6</sup> Average salt intake in the United States far exceeds that required for growth and development; thus, the limitation of dietary sodium to 4 to 6 grams per day poses no risk to the individual. MacGregor<sup>8</sup> demonstrated that the blood pressure lowering effects of sodium restriction are additive to those of antihypertensive medications. Therefore, it is recommended that all hypertensive patients receive counseling on lowering dietary sodium<sup>1,6,8</sup> to include information on sodium content of processed foods such as canned and frozen foods and "junk food."<sup>6</sup>

Thus, children with high normal blood pressure should be on a nonpharmacologic antihypertensive regimen, and patients with significant hypertension should receive a trial of nonpharmacologic management of their blood pressure prior to beginning antihypertensive drug therapy.<sup>1</sup> The lowering of blood pressure through weight loss, exercise, and dietary sodium restriction does

require a high level of patient motivation, but it also provides a sense of satisfaction and accomplishment when successful.<sup>2</sup> Nonpharmacologic measures should be used along with medication in patients in whom drug therapy proves necessary since weight control, exercise, and sodium restriction may decrease the required dosage of medications.<sup>1</sup>

#### Pharmacologic Therapy for Hypertension

As mentioned previously, pharmacologic therapy for hypertensive children and adolescents is reserved for those with severe hypertension ( $\geq 99$ th percentile) and for those with significant hypertension in whom a trial of nonpharmacologic therapy has proven unsuccessful. Using these guidelines,  $<1\%$  of children in the United States should be exposed to the risks of antihypertensive medications. Risk of each therapeutic regimen must be carefully considered and nonpharmacologic therapy should be continued along with drug

therapy with the goal of maximum therapeutic benefit with minimum drug dosage and side effects.<sup>1</sup>

The second task force on blood pressure control in children proposes a stepped-care approach to drug therapy in children with essential hypertension<sup>1</sup> which is similar to that traditionally used in adult patients.<sup>6</sup> Step 1 begins with a small dose of a single antihypertensive agent, generally a thiazide-type diuretic or an adrenergic inhibitor. More recently, captopril, an angiotension converting enzyme inhibitor, has proved efficacious as a step 1 drug, particularly in children with renin dependent hypertension.<sup>9</sup> Once the initial drugs is begun, its dosage is gradually increased until target blood pressure is reached, side effects are present, or the maximum drug dosage is reached. If maximum drug dosage is reached or intolerable side effects are present without

***“Less than 1% of children in the United States should be exposed to the risk of antihypertensive medications.”***

adequate blood pressure control, a different drug may be tried. Step 2 begins with a second drug with a different mechanism of action is added to the drug already in use. Again, therapy is begun with a relatively low dose which is gradually increased as in step 1. Essential hypertension in children and adolescents is generally quite responsive to drug therapy; therefore, a child who is thought to have essential hypertension but

does not respond to a combination of two antihypertensive agents should be reevaluated to look for a previously undetected cause of secondary hypertension. If no such cause is found and the hypertension remains uncontrolled, step consists of the addition of a third agent with still another mechanism of action, often a vasodilator; the dosage of this third agent is then slowly increased as in steps 1 and 2.<sup>1</sup> It is important to remember that combination antihypertensive therapy is based on the use of various drugs with different mechanisms of action; thus, the choice of two drugs with the same mechanisms of action would be inappropriate.<sup>2</sup>

***“The stepped-care approach is generally used in children and adolescents with essential hypertension while the treatment of secondary hypertension is aimed at correction of the underlying cause.”***

An important part of antihypertensive therapy which is often neglected is the step-down phase. After the blood pressure has been effectively controlled over a long period of time the medication dosage should be slowly decreased to the lowest effective dose. The blood pressure must be carefully monitored during this phase. Thus, the change of drug side effects is

minimized and patient compliance enhanced.<sup>1</sup>

The stepped-care approach is generally used in children and adolescents with essential hypertension while the treatment of secondary hypertension is aimed at correction of the underlying cause. There are certain cases of secondary hypertension in which pharmacologic control of the hypertension may become necessary and requires special consideration. For example, in cases of hypertension secondary to hyperthyroidism, beta blockage is used to control the hypertension and concomitant tachycardia.<sup>1</sup> Alpha blockade is the first line in therapy in hypertension secondary to catecholamine excess states; a beta blocker may be required to control tachycardia following alpha blockade.<sup>9</sup>

**T**here are many antihypertensive medications available for use in the pediatric patient. The treatment regimen for each patient must be individualized based upon the degree of hypertension and response to different medications along with development of side effects and presence of other medical conditions. As long-term effects of antihypertensive therapy in children and adolescents are unknown, the need for medication in these patients and development of unwanted drug effects must be continually evaluated.

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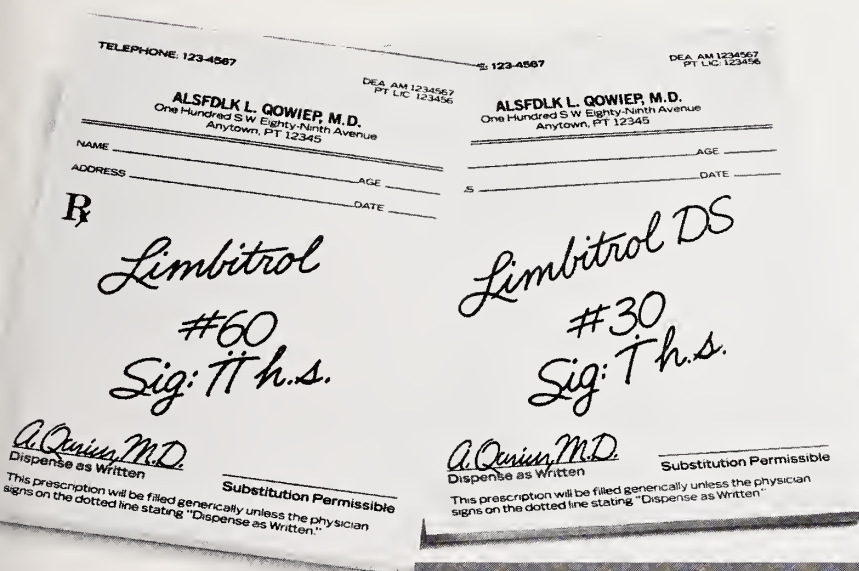
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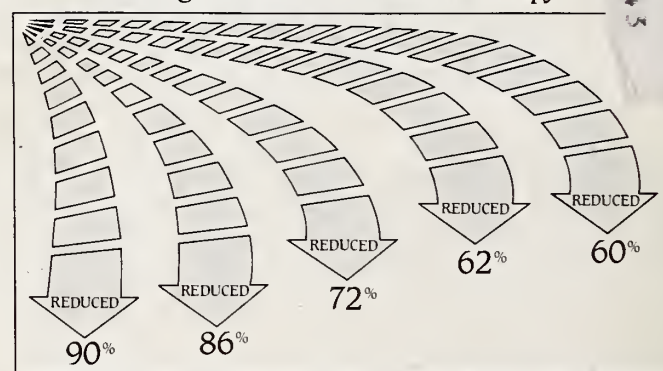
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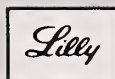
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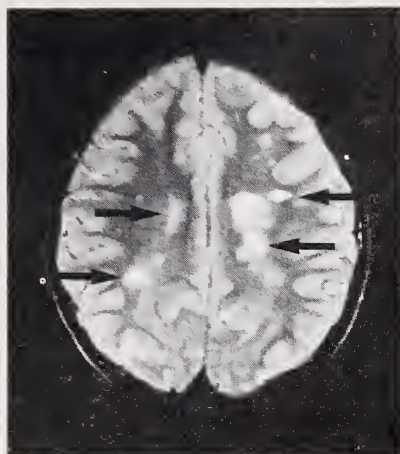


Figure 1



Figure 2

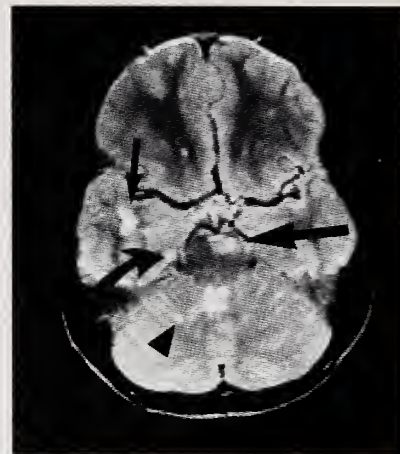


Figure 3

## CLINICAL INFORMATION:

Recently, there has been much discussion in the literature of the neurological symptoms caused by the spirochete *Borrelia burgdorferi*. The disease is transmitted by a tick bite and is associated with clinical symptoms of headaches, multiple arthralgias, and non-specific neurological symptoms. Given the appropriate clinical history, a diagnosis of Lyme disease can readily be confirmed by an MR scan.

**FINDINGS:** Figure 1 is a T2-weighted axial image through the brain. Abnormal focal areas of increased signal intensity can be identified within the centrum semiovale bilaterally (small arrows). These lesions are primarily located within the white matter but are of differing sizes. Figure 2 is also an axial image through the brain but at a level through the lateral ventricles. This section shows a

lesion located within the medial gray matter of the right frontal lobe anterior to the corpus callosum (large arrow). Additional areas of abnormal increased signal intensity can be identified adjacent to the occipital horns, in the gray-white matter interface of the left parietal operculum (small arrow), and in the deep white matter of the frontal lobes in the region of the anterior corona radiata (arrowheads). Figure 3 is through the posterior fossa as well as the lower frontal and temporal lobes. Abnormal areas of increased signal intensity are demonstrated in the left anterior pons (large arrow) in the anterior right temporal lobe (small arrow), in the right cerebellar peduncle (arrowhead), and in the medial right temporal lobe (curved arrow).

The MR images clearly demonstrate the predominantly white matter involvement, multifocal nature, and the absence of

mass effect associated with these lesions. In the absence of clinical history, the MR appearance would be most consistent with a demyelinating process such as multiple sclerosis. However, as this case presented in a nine year old male following exposure to ticks, the differential diagnosis becomes that of Lyme disease. The diagnosis was further confirmed by the findings of similar, although less extensive lesions, in the patient's sibling.

**COMMENT:** The patient in the case above had a CT scan prior to the MR study which was negative. This case clearly demonstrates the increased sensitivity of MR over CT in detection of white matter processes. However, the case also demonstrates the relative non-specificity of the findings. In this case, the clinical history was most important in determining the true etiology of the patient's findings.



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**THE COVER**

Lyme disease with its classic vector-host-parasite relationship is beautifully depicted on the cover by Statesboro artist, Susan Oliver. See p. 651 for more information about this gifted artist.

*Ixodes dammini*, the deer tick, is the main vector in the eastern United States. Shown within the tick's body are natural hosts, the white-footed mouse and the white-tailed deer, and man, the accidental host. The yellow-stained spirochete, *Borrelia burgdorferi*, is the etiologic agent. There have been 299 positive and 84 probable human cases of Lyme disease in Georgia during the first 7 months of 1989, according to the Georgia Department of Human Resources.

The articles beginning on p. 675 and 679 and the editorial on p. 665 discuss the epidemiologic, etiologic, clinical, and prevention aspects of this disease.

Dear Editor,

**C**ongratulations on the August MAG *Journal on Rural Medicine and Hospitals*.

There have been two in depth studies of which I am aware that related to rural physician populations and state needs. The report by Dever et al. was enlightening, but there are problems not referred to in the report that will skew physician population figures in rural areas drastically in the next ten years.

The oldest average specialty was General Surgery as reported in the article. However, Family Practice was not created as a specialty until 1969, and the exodus from general practice into specialty and sub-specialty medicine began in probably 1959. The general practitioners that graduated in 1959 have now been in practice almost thirty years, are approaching 60, and I suspect because of the present medical environment and atmosphere will retire in the next five years.

For these reasons I suspect that the *average* age of Family/General physicians is not a useful figure but should be further subdivided to account for the hiatus from 1959 to 1969.

Because many of the newly graduating residency trained family physicians desire proximity to a large metropolitan area, counties with populations less than 20,000 will lose physicians in amounts that cannot be replaced by the newly graduating residents.

In the original Georgia Primary Care Manpower Study done in 1976, an assumption was made that physicians would practice until 70 years of age. Using this assumption, the percentage of these physicians would increase from 26 percent in 1990 to 51

percent in 1995. Assuming a younger retirement age (which is now probable), the percentages will be skewed toward earlier dates and greater numbers of physicians leaving communities of less than 20,000 population.

This seems to spell disaster for those counties with less than 20,000 population. I suspect that by 1995 these smaller counties

will lose at least 65 percent of their physician population unless some new trends are created. There are 88 of the 159 counties in Georgia that fall into this category.

Sincerely,  
Stephen C. May, Jr., M.D.  
Family Practice, Kennesaw

## Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

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Many people are confused about the effects of alcohol on the liver—and *what you don't know can hurt you*.

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## About the Cover Artist

# Susan S. Oliver



*Artist Susan S. Oliver is shown here with two of her recent works, a triptych of "White Ibis" and "Four Xhosa Tribeswomen" from South Africa.*

**G**raduating from Hood College, Frederick, Maryland, with a major in zoology and two minors in chemistry and art, Sue had the goal of becoming a medical illustrator, and thus it seems especially appropriate for her to have designed the cover art for this issue of the *Journal*. Meeting and marrying her husband Jim diverted her from her original goal but certainly gave her enriching challenges. Of these, the most rewarding were two sons and a peripatetic lifestyle which has taken them to every continent on this earth, with the exception of Antarctica, to allow Jim to conduct biomedical research emphasizing arthropod vectors of diseases.

Sue's professional art reflects the exposure to the

various cultural influences of their travels and to the spectacular beauties of the natural world. Although portrait work has been her primary focus, in recent years she has devoted more and more time to landscape and wildlife art. In these she finds a more intensely personal form of expression which allows her esthetic appreciation and scientific interest to blend. Sue can imagine no greater challenge and excitement than taking a two dimensional canvas and, by using form and color, creating a painting which conveys a three dimensional image with an emotional impact.

Her studio is located at 115 Benson Dr., Statesboro, GA; 912-681-3550.

# Why Do Physicians From Around The U.S. Send Kids To One Atlanta Hospital For Old-Fashioned Care?

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therapists, who are very creative and skilled at working with families outside Atlanta. There is an on-campus school — the equal of most private academies — offering class sizes of 6-10.

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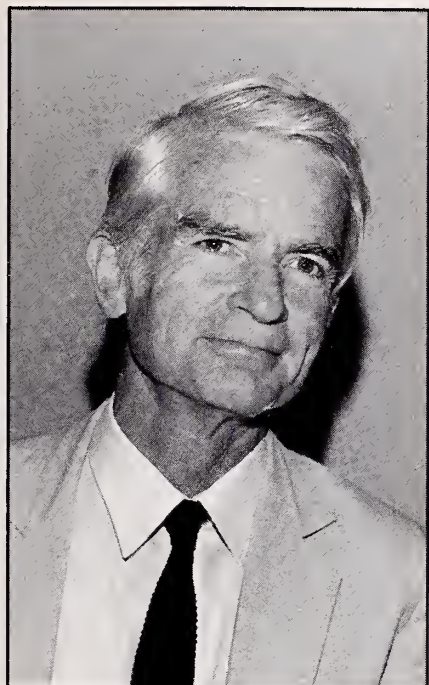
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Joe L. Nettles, M.D.

## *Delivering Help to OBs*

**A** FORMER PRESIDENT of the American College of Surgeons entitled his farewell address "Don't just do something — stand there!" I have always adhered to Thomas Jefferson's advice, "He who governs least, governs best." Likewise, "If it ain't broke, don't fix it." However, we have reached a crisis in the obstetrical delivery system in this state. A recent survey shows that the number of physicians delivering babies 10 years ago has now been reduced by greater than 50%.

At last week's MAG Legislative Seminar in St. Simons, we listened to Dr. Murray Freedman, the president of the Georgia Obstetrical and Gynecological Society. Even though he is a young physician, Dr. Freedman no longer practices obstetrics, having stopped 2 years ago because of the constant threat of malpractice.

Even though it has been shown that 90% of birth defects have nothing to do with medical management and delivery, the physician is often held responsible for a less than perfect baby. When a defective or brain-damaged baby is brought before a jury, no matter the cause, the jury's sympathy is aroused and the baby will be cared for; even if it is unjustly at the expense of the obstetrician and his or her insurance carrier.

The rapid acceleration in the number of lawsuits and the increased size of awards make the practice of obstetrics similar to playing Russian roulette. Moreover, despite the recent reduction in the statute of limitations for minors to 7 years, the claim and the constant threat of a claim may hover on the horizon for long after the physician's retirement. Given the present situation, I honestly cannot understand how any physicians would submit themselves and their families to the stresses of delivering babies.

**W**e have "stood there" long enough. It is now time to do something. The previously passed tort reform package has helped all of us except our obstetrical colleagues. The focus of this year's legislative efforts will be toward obstetrical relief. Under consideration is an arbitration panel to rule in the cases of the neurologically impaired baby. This is plowing new ground, and we are not certain that it will be the proper answer. The figures of claims may not be reduced, but the size of the awards and most importantly the period of time in settling the case will likely be greatly reduced. This may be the first step in delivering help to obstetricians and insuring that our children and grandchildren will receive proper care.

*Joe Nettles*

## NEW MEMBERS

Burnside, H., II, Internal Medicine — Gordon (Active) — 102 Hospital Court, P.O. Box 1629, Calhoun 30701

Culler, Floyd L., Pediatrics/Endocrinology — MAA (Active) — 2040 Ridgewood Dr., Atlanta 30322

Daugherty, J. Thomas, Family Practice — Floyd-Polk-Chattooga (Resident) — Floyd County Hospital, Rome 30161

Davis, Paul M., III, Orthopaedic Surgery — MAA (Active N2) — Northwest Medical Ctr., Ste. 309, 3280 Howell Mill Rd., N.W., Atlanta 30327

Dennard, David T., — Internal Med./Nephrology — Whitfield-Murray (Active N2) — 1007 Professional Blvd., P.O. Box 1572, Dalton 30720

DeSantis, James M., Family Practice/Emergency Medicine — Cobb (Active) — 3901 Regas Dr., Marietta 30066

Fisher, Michael S., Internal Medicine — MAA (Resident) — 6822-D Glenridge Dr., Atlanta 30328

Gordon, David S., Oncology/Internal Medicine — MAA (Active) — 1365 Clifton Rd., N.E., Atlanta 30322

Kim, Kee-Cho, Pediatrics — Baldwin (Active) — Central State Hospital, Milledgeville 31061

Kulangara, Raju J., Pediatrics — Tift (Active) — 802 E. 18th St., Tifton 31794

Myers, Robert C., Family Practice — Altamaha (Active) — 114 Hester St., Hazlehurst 31539

Pribyl, Charles R., Orthopaedic/Hand Surgery — Troup (Active) — 303 Smith St., LaGrange 30240

Randolph, Christopher S., Psychiatry — Whitfield-Murray (Active) — 2410 Shannon Dr., Dalton 30720

Slagel, G. Anthony, Dermatology — Clayton-Fayette (Active) — 101 Yorktown Dr., Fayetteville 30214

Straus, Barry N., Anesthesia — Cherokee-Pickens (Active) — 12190 Charlotte Dr., Alpharetta 30201

## PERSONALS

### *Bibb CMS*

**William H. Terry, III, M.D.**, has been appointed the B. T. Hartley Professor of Medicine (Nephrology) at Mercer University School of Medicine in Macon. A graduate of Georgia Tech and the Medical College of Georgia, Dr. Terry has been a full-time faculty member of the Department of Internal Medicine at the Mercer School of Medicine since 1983.

### *Medical Association of Atlanta*

**Nanette K. Wenger, M.D.**, Professor of Medicine (Cardiology), Emory University School of Medicine, has been appointed to a Committee of the Institute of Medicine to evaluate acute myocardial infarction for the Health Care Financing

Administration (HCFA) with regards to its Effectiveness Initiative Program.

Dr. Wenger also served as an invited lecturer at the International Symposium on Heart Failure: Mechanisms and Management in Jerusalem, Israel, in May, 1989; and at the II International conference on Preventive Cardiology in Washington, DC, June 1989. She served as Chairman of the International Organizing Committee of the II Asian Pacific Symposium on Cardiac Rehabilitation held in Jerusalem, Israel, in June, 1989, at which she also delivered plenary and symposium lectures.

### *Muscogee CMS*

**Champ Baker, M.D.**, of the Hughston Orthopaedic Clinic in Columbus, was awarded an honorary membership in the National Athletic Trainers Association (NATA) during its annual Clinical Symposium and Workshop in Dallas, Texas, June 12-15.

### *Thomas Area CMS*

**Jeff Byrd, M.D.**, a member of the John D. Archbold Memorial Hospital medical staff, was elected president of the Georgia Association of Pathologists at its annual meeting held at the Medical College of Georgia in Augusta. **Bob Baisden, M.D.**, Professor of Pathology at the Medical College of Georgia, was elected vice president.

Dr. Byrd had previously served as secretary-treasurer and has been a member of the Board of Governors of the Association for the past 4 years. As president of



the state organization, he will be responsible for coordinating professional and legislative activities at the state and national level, developing educational programs, and implementing programs to encourage qualified individuals to enter the health-related laboratory field.

Dr. Byrd, who is medical director of Archbold's laboratory, is a member of the joint conference and planning and equipment committees, past president of the medical staff, and president of Qualicare.

## QUOTES

*Human society is ordered, productive and in accord with human dignity only if it is based on truth.*

POPE JOHN XXIII

*The years teach much which the days never know.*

RALPH WALDO EMERSON

*A light and trifling mind never takes in great ideas, and never accomplishes anything great or good.*

WILLIAM SPRAGUE

*Difficulties, like work, are blessings in disguise. Life would become monotonous, colorless, deadening without them. Difficulties should act as a tonic; spur us to greater exertion, strengthen our will power. Study this subject through to the bottom and you will arrive at this conclusion: Thank God for difficulties.*

B. C. FORBES

## CHIRON STATUE AVAILABLE

*"I swear by Apollo the physician and Aesculapius ... that I will keep this oath ..."*

So begins the Hippocratic Oath, the ceremonial vow all physicians give before being granted their diplomas. The oath is sworn to Aesculapius, the mythical Greek god of healing.

Aesculapius was the son of Apollo and a mortal woman, Coronis. All were struck by his extraordinary intelligence. Apollo entrusted his son's care and education to Chiron, a centaur, half man and half horse. Chiron was then the most gifted of all physicians. He taught Aesculapius his entire art, and the young physician soon improved upon his master's methods.

Aesculapius learned from Chiron the use of herbs and salves. From snake's venom he learned to bring the dying back to life. He carried these healing snakes on his staff throughout the lands.

Hades, the god of the underworld, was enraged by this interference with death. After Hades bitterly complained to Zeus about Aesculapius robbing him of the dead, Aesculapius was struck down by a lightening bolt. Only the intervention of Apollo caused Zeus to bring the physician back to life. Aesculapius was placed among the constellations. Soon temples of healing bearing his name were built throughout Greece, and an order of physicians was established.



*According to Greek mythology, the center Chiron taught Aesculapius his entire healing art, including the use of herbs and snake venom.*

To commemorate his continuing tradition of teaching medicine, Michael Burton, a professor of art at Floyd College in Rome, Georgia, has created a bronze statue of Chiron the teacher holding aloft the young physician Aesculapius. Using the lost wax method, this 18"x12"x6" statue with a marble base embodies the joy of continued learning and teaching which makes medicine the wonderful profession it is.

A limited number (50) of these statues are available for purchase. The price of a statue including freight and insurance is \$1850. A \$300 portion of this price is a tax deductible contribution to the Georgia Association of the Deaf. Call (404) 748-8542 or write: Michael Burton, Booger Hollow Studios, Inc., Cave Spring, GA 30124 for further information.

*Submitted by Jeffrey Kunkes, M.D.*

## DEATHS

**Robert A. Burns, M.D.**, of Blue Ridge, who was recently honored by residents and peers there with the title of Chief of Staff Emeritus and a medical building named after him, died July 9 of lung cancer at the age of 64.

Dr. Burns began his family practice when he opened the Burdine Clinic in Blue Ridge in 1950. He was the first chief of staff at Fannin Regional Hospital when it opened in 1978. A Korean War veteran, his practice was interrupted while he served in the U.S. Air Force in 1952-54.

For a time, he was the only physician in the Blue Ridge community until the Copper Basin Medial Center was built in 1955. He retired from practice in January of this year.

Dr. Burns graduated from Wake Forest University and received his medical degree at Bowman-Gray Medical School. Special honors were bestowed upon him in June when a reception was held for him extolling his contributions to the community. A signed resolution was passed jointly by the medical staff, Community Health Systems, and owners of the Fannin Regional Hospital.

**William Henry Lucas, Jr., M.D.**, an internist from Rome, died from cancer last June at the age of 59.

"The thing he regretted most was that he wasn't able to practice medicine for as long as he wanted," said Dr. C. J. Wyatt, a longtime friend. "He cared very much for his patients. The patients all loved him because he was a friend as well as a doctor. He wrote before he died that his patients were like his family."

Dr. Lucas was born in 1930 in Stillmore, Georgia. He served as a captain in the Army Medical Corps. He was a 1951 graduate of Emory University and was graduated from the Medical College of Georgia in 1955.

He completed his internship at St. Joseph's Hospital in Atlanta in 1956 and operated a general practice in Cedartown with his father from 1956 until 1957. He established his practice in Rome in 1962 until his retirement.

Board certified internal medicine in 1965, Dr. Lucas held memberships in several professional associations. He served as president of the professional staff of Floyd Medical Center and as chairman of the Floyd County Board of Health.

**Eugene Long Ward, M.D.**, an otolaryngologist from Gainesville, died last July at the age of 83.

A native of North Carolina, Dr. Ward settled in Gainesville in 1933 after graduating from Emory University School of Medicine. He began his medical work in the clinics of Chicopee, New Holland, and Gainesville Mill industries and later practiced in partnership with Dr. C. G. Butler until Butler's death in 1953.

He served as chief of staff at the Hall County hospital and as president of the Hall County Medical Society and the Ninth District Medical Society. He was a staff member of Northeast Georgia Medical Center and Lanier Park Hospital.

Dr. Ward, who retired last December, is best remembered by his patients for his personalized care. According to one patient, "He was one of the kindest people you ever saw, and he was very involved in the community."

## QUOTES

*There are almost as many forms of recreation and diversion as there are human beings. But it can be laid down as a universal rule that every man, woman and child needs some kind of recreation, some kind of entertainment, some kind of amusement. We all have to fight the battle of life. Whether we use our leisure to recreate power or dissipate power is of decisive moment.*

B. C. FORBES

*A man should work eight hours and sleep eight hours but not the same eight hours.*

ELMER G. LETERMAN

*Everyone has a code of ethics for everyone.*

ROBERT HALF

*Gossip is when you hear something you like about someone you don't.*

EARL WILSON

*I have no enthusiasm for nature which the slightest chill will not instantly destroy.*

GEORGE SAND

*Respectability: The offspring of a liaison between a bald head and a bank account.*

AMBROSE BIERCE

*Anybody who believes that the way to a man's heart is through his stomach flunked geography.*

ROBERT BYRNE

*Medicine is the only profession that labors incessantly to destroy the reason for its own existence.*

JAMES BRYCE, 1914

*Success has ruined many a man.*

BENJAMIN FRANKLIN



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**Program Registration form appears in the October MAG NEWSLETTER — or call Suzanne Silberman at the MAG headquarters in Atlanta — 876-7535 or 800/282-0224.**

## OCTOBER

18 — *Augusta: Pain Management in the Primary Care Setting*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

23-24 — *Atlanta: Quantitative Thallium Myocardial Tomography*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-27 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

26-27 — *Atlanta: Women's Health Care: A National Challenge, 8th Annual Conference on Reproductive Health Conference*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

28 — *Atlanta: Day of Pediatrics — Pediatric Approach to the Evaluation and Management of Hearing and Speech Disorders*. Category 1 credit. Contact Scottish Rite Children's Hospital, CME Office, 1001 Johnson Ferry Road, Atlanta 30363. PH: 404/256-5252.

28-31 — *Atlanta: 23rd Scientific Session/24th Annual Meeting, American Academy of Environmental Medicine*. Category 1 credit. Contact Dr. Wackerman, A.A.E.M., Box 16106, Denver, CO 80216. PH: 303/622-9755.

29-3 Nov. — *Sea Island: Georgia Obstetrical & Gynecological Society*.

Category 1 credit. Contact Chester Lane, 69 Butler St., Atlanta, 30309. PH: 404/659-0289.

29-4 Nov. — *Atlanta: Congress of Neurological Surgeons*. Contact CNS, 1840 North Soto St., Room 100B, Los Angeles, CA 90033. PH: 213/224-5435.

## NOVEMBER

5-8 — *Peachtree City: Group Leadership Conference*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

9-11 — *Atlanta: Georgia Academy of Family Physicians*. AMA Category 1 credit & AAFP prescribed. Contact Camille Day, GAFFP, 3760 LaVista Rd., #100, Tucker 30084. PH: 404/321-7445 or 800/392-3841.

10-12 — *Atlanta: Gastroenterology for Primary Care Physicians*. Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

11 — *Atlanta: Anticonvulsants in Psychiatry: Update 1989*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

16 — *New Orleans, LA: Advances in the Diagnosis and Treatment of Cardiovascular Diseases*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton

Rd., Atlanta 30322. PH: 404/727-5695.

17-19 — *Atlanta: MAG Scientific Assembly*. Contact MAG, Dept. of Education, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

17-20 — *Peachtree City: 26th Annual Psychiatric Institute on Group Behavior and Group Leadership*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19 — *Atlanta: Gearing Up For Retirement*. Category 1 credit. Contact S. Hill, American Medical Association, Dept. of Practice Management, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/645-4958.

## DECEMBER

2-3 — *Atlanta: Regional Anesthesia: Surgery, Obstetrics, and Pain*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-8 — *Atlanta: Magnetic Resonance Imaging*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-8 — *Atlanta: Nuclear Medicine Update: Infection, Renal, Cardiac, Brain & Lung Imaging, with Emphasis on SPECT*. Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



## Georgia Hospitals to Meet with Gubernatorial Candidates

**T**he Georgia Hospital Association will bring the issues of health care to candidates for governor and lieutenant governor at its Fall Political Education Seminar October 26-27 in Atlanta. The purpose of the program is to give hospitals a first-hand view of candidates' opinions and also to present hospitals' concerns.

GHA has invited Rep. Lauren (Bubba) McDonald, Jr., of Commerce, Lt. Gov. Zell Miller of Young Harris, Rep. Johnny Isakson of Marietta, and Sen. Roy Barnes of Mableton, all candidates for governor. Atlanta's mayor Andrew Young, who is considered likely to run in the governor's race, has also been invited.

Candidates for lieutenant governor who have been invited are Rep. Jim Pannell of Savannah, Sen. Joseph Kennedy of Claxton, Sen. Pierre Howard of Decatur, Sen. Lawrence Stumbaugh of Stone Mountain, Sen. Wayne Garner of Carrollton, and Janice Horton of McDonough.

## House Cuts Surtax Rate for Catastrophic Coverage

**B**owing to pressure from opponents of the Catastrophic Coverage Act, the House Ways and Means Committee has agreed to cut in half the surtax rate, which about 40% of the elderly would pay.

But that cut, argued some congressional members, will drain nearly \$10 billion from the Medicare Hospital Insurance Trust Fund over the next 5 years. Ways and Means's response was to let hospitals and doctors take up the

slack, and it has now proposed to delay Medicare payments for both Part A and Part B claims by 5 days at the end of FY 1990, by 6 days at the end of FY 1991, by 3 days in FY 1992, and by 1 day in FY 1993.

The act remains unpopular in Congress, and there has even been one attempt to repeal it entirely. But repeal seems unlikely, as it would add \$6.5 billion to the federal budget deficit and could trigger across-the-board cuts to satisfy the provisions of the Gramm-Rudman law.

## Medicare to Become "Painful" for Hospitals

**F**iscal year 1991 is expected to bring hospitals even more drastic Medicare payment reductions than 1990, according to top government officials.

Kevin Moley, assistant secretary for management and budget for the Department of Health and Human Services, has told hospitals that Congress's efforts to reach the 1991 Gramm-Rudman budget deficit target will affect doctors, hospitals, and suppliers of durable medical equipment "painfully," even to the extent that "a lot of hospitals in the country may not survive." The deep cuts will come, he says, because Congress has not yet responded to the administration's requests to reduce the Medicare budget.

## Health Care to Account for 13.1% of Gross National Product

**I**n the next 6 years, health care costs may well reach 13.1% of the gross national product, says one group of financial experts that includes bankers, economists, and health care

executives. In fact, one of the group sees that amount climbing as high as 15%.

One of the factors, they say, will be a labor shortage, which will drive hospitals wages up further. Another is that efforts to keep costs in line are being overshadowed by the growing number of persons who cannot afford health care coverage.

## Hospital Bond Ratings See Significant Drop

**S**tandard & Poor's Corp. reports that its downgrades of hospital bond ratings were 10 times greater than upgrades during the second quarter of this year. And for the first 6 months of the year, S&P downgraded 21 hospital bond issues and upgraded only four. The reasons for the declining ratings, says S&P, include additional debts, low operating profits, poor cash flow, and losses in market shares.

## Survey Shows Americans Favor Limiting Doctors' and Hospitals' Fees

**A** Boston-based political polling firm has found that 80% of Americans would like to put limits on what doctors and hospitals can charge.

The poll, conducted by Harrison and Goldberg, showed that most of the 1,000 respondents also thought employers should pay for at least minimum health coverage for their employees. In addition, they thought the government should pay for health care for persons who can't afford it.

And 86% of the people surveyed said that persons who don't have employer-sponsored health coverage and who aren't eligible for Medicaid should be able to buy into Medicaid.

*From Bynum's Scrapbook . . .*

*A Plea*

Give me one friend, just one, who meets  
The needs of all my varying moods,  
Be we in noisy city streets,  
Or in dear Nature's solitudes.

One who can let the world go by,  
And suffer not a minute's pang;  
Who'd dare to shock propriety  
With me, and never give a hang.

Who on my rarely righteous streaks,  
Should love me — love not the less,  
When I am given to outbreaks  
Of pure besotted selfishness.

One who, when I am sick and glum,  
Can lay conventions on the shelf,  
And just for my dear sake become,  
A blooming heathen, like myself.

One who can share my grief or mirth,  
And know my days to praise or curse,  
And rate me for just what I am worth,  
And find me still — Oh, not so worse!

Give me one friend, for Peace or War,  
And I shall hold myself well blest,  
And richly compensated for,  
The cussedness of all the rest!

ESTHER M. CLARK.

*(Submitted by Richard Bynum Weeks, a retired surgeon, St. Simons Island.)*



## Of Writing and Editing

*"Writing is both mask and unveiling."*

E. B. WHITE

*"I do think that the quality which makes a man want to write and be read is essentially a desire for self-exposure and is masochistic. Like one of those guys who has a compulsion to take his thing out and show it on the street."*

JAMES JONES

*"I write in order to attain that feeling of tension relieved and function achieved which a cow enjoys on giving milk."*

H. L. MENCKEN

*"Writing is utter solitude, the descent into the cold abyss of oneself."*

FRANZ KAFKA

I HAVE ALWAYS THOUGHT it reasonable, the question on occasion put to me, as to why one expends the effort to edit a medical journal such as ours, or any journal for that matter. Why, indeed, does one even bother to write? It is said by all to be a labor. Perhaps some answers rest in the above thoughts of others who labor with pen and paper. For myself, the answer eludes and is irrelevant.

We must with some ongoing regularity assess that corner of this universe in which we find ourselves as well as those activities which involve, concern, or consume us, else we fall victim to the soul-destroying sameness

of life. In such a view, we look this month at our *Journal of the MAG* and at its Editorial Policy. We look at it from two perspectives. One, that of your current editor who asks, "Whence the Editor?" The other, a view of Editorial Policy from another Georgian and yet another time, Joel Chandler Harris writing in 1878 who says that "An editor must have a purpose."

### Whence the Editor?

We were talking about the Editor's Corner that day, the Managing Editor and myself. We had discussed the matter earlier in our relationship in fact. "Why do you want to call it the Editor's Corner?" she said in that directional way she had of expressing an opinion. "It's so ordinary, so common, so unimaginative, it seems to me."

"Well," I said, "it's my Corner, my opinion, and so why can I not crouch in my Corner and say what I care to and call it what I care to call it?"

That was awhile back. Back at a time when I had been, with some justified trepidation, declared the Interim Editor of the State Medical Journal. The matter at hand on this occasion, however, rested not with so unimportant and mundane an issue as the title of the writing but with the opinion expressed in this particular Editor's Corner.

It was some time following that encounter when we met in the

weekly review of our journalistic efforts. "I have edited your Corner a bit more than usual. I hope you agree. It seemed necessary," she said. I looked it over. The punch line had been taken out. A few commas added, an occasional dash eliminated. Things of little import had been altered. Little worry or concern unless one viewed himself a literary avant-garde. A Faulkner. A Robertson Davies. I saw myself as no such person. My problem lay far beyond commas. Far beyond dashes and periods. My problem lay in Exclamation Points.

All must, or should, write from their own experience. From their own day-to-day existence.

"What in the name of Heaven is wrong," I said to her, "with my saying, 'We are the King's physician and from that high pinnacle survey our kingdom?' Why did you strike that out in your editing? What possible objection could you have to so clear and understandable a statement?"

"It sounds arrogant," she said. "It confirms what the public, what your patients, think of doctors. They all see you as gods, above and better than they. They see you as unapproachable. I know you are not that way, but when you make such statements you tend to confirm that impression."

I shuddered. Me arrogant? Me unapproachable? And so I said to her, "You seem not to understand. What I write is for my peers, for the doctors of this state.

It is not intended for public consumption. The doctors will understand, though not all agree with what I say. I talk in my Corner of issues, of concerns that address themselves to the physicians of this state. You may play around with the commas but leave the issues alone."

We stopped there. The commas, the dashes, were altered. The arrogance softened, and the Corner went to the printer. The worry plagued me for days thereafter. Was I to be a linguist, buffeted about by the technical purist of the language? Worse yet, a malcontent tethered by the withering thought of, "What will they think of what I have written?" Or, Heaven help me, "Will they agree with me?"

**W**e had come to an amicable agreement, the MAG Executive Committee and I, for it serves as the Publications Committee of the *Journal*. In the end, I answer to them. When I had first been named Interim Editor, and later on, Editor, it was agreed that a certain degree of restrained journalistic freedom would accompany the task. I had written in that first Corner, "I have made several requests of the members of the Executive Committee. I have asked that the Contributing Editors, many of whom have assisted with the *Journal* for a number of years, be studied and revised. We are in the process of doing this. I have made suggestions as to changes in the publication which can, in the future, help us maintain the *Journal's* present reputation of excellence as well as continue, in the future, to provide an interesting and informative medium for the exchange of ideas amongst the members of the

profession. I have requested that I be allowed to write each month an Editor's Corner with a view toward expressing personal views and opinions regarding topics that seem of importance, and that request has been granted. It was a final and granted request that the *Journal of the MAG* be allowed to continue its past policy of journalistic independence with the understanding that the membership of the Association and the officers thereof to whom has been entrusted the management of the affairs of the Association be always viewed as the ultimate authority governing the continuing journalistic policies of the publication. It is only in the unfettered environment of journalistic freedom that one can expect to derive the greatest benefit from any individual's effort. It would be my hope, then, that during this transition period your Interim Editor and the Editorial Board can continue to produce for you a *Journal* that is respected among its peer publications, interesting and informative and provocative to the members of the Association — and to some degree controversial, in the sense that easy and ready answers, or opinions, are often dangerous and wrong. Or as H. L. Mencken put it, 'To every complex problem there is an answer which is simple, clear and wrong.' "

**A**nd so much in the same vein do I see the undertaking now some 2 years distant. All must, or should, write from their own experience. From their own day-to-day existence. Surely they must write from their firmly held convictions or understandings of issues. There seems to be no other way. Else Fitzgerald could not have written of carousing

parties or Hemingway of bullfights. Surely Conrad could not have portrayed so vividly the travails of the ocean voyager. Thus must the physician write of his or her experience. The Editor of a State Medical Journal writes of those matters that in the course of his or her professional life rise up as issues to be addressed. So must he or she write, not with the fragility of concern that the writing will be disagreed with or that others to which it be not addressed will take issue with it, but rather with the clear conviction that an issue at hand need be addressed. An experience or concern communicated as best it can be from one's personal self and with the understanding that all who read the writing will not agree. The Editor's Corner in a State Medical Journal is a place into which one retreats to reflect upon the concerns that must, of necessity arise from the day-to-day practice of medicine, whether it be in the office of the practitioner or the laboratory of the investigator and researcher, a place where personal contact with the physically afflicted of our world lends insight into the betterment of the conduct of the profession, a place where the ills of the profession are openly and frankly discussed and earned plaudits rendered, a battlefield where commas and dashes and exclamation points give way to ideas and opinions themselves at odds with age-old concepts and rigidly held positions. Literary? Perhaps. Grammatically correct? To some extent. Controversial? To a point. Helpful, constructive, and thoughtful? Always. Whence the Editor?

Charles R. Underwood, M.D.



## An Editor Must Have A Purpose

An editor must have a purpose. He must have some object in view beyond the mere expression of an opinion or the publication of a newspaper. The purpose may be either moral, social, or political, but it must be well defined and pursued constantly.

I shudder when I think of the opportunities the editors in Georgia are allowed to slip by. It grieves me to see them harping steadily upon the same old prejudices and moving in the worn ruts of a period that was soul-destroying in its narrowness. There never has been a time when an editor with a purpose could accomplish more for this state and his country than at present.

What a legacy for one's conscience to know that one has been instrumental in mowing down the old prejudices that rattle in the wind like dry weeds! How comforting to know that one has given a new impulse to timid conviction! But an editor with a purpose can do more than this; he can sweep away all false conditions in society and politics and bring his fellows back to the sweet simplicity of the ancient days. Provided he be earnest. This is everything.

What if it requires a generation of time to reform a generation of men? The flight of the swallow is swift, but it conveys no idea of permanency. A good writer need not be an editor, but an editor needs to be a writer, and a vigorous one; no gifts of the intellect will compensate the lack of a purpose. Let him play the politician if he will, but always as an editor.

In the South, John Forsyth made an impression that will be permanent; in the North, Samuel

Bowles. These men were editors with a purpose, and whatever part they took in politics was subservient to that purpose. In the South today we sadly need the resurrecting hand of editors with a purpose; who will supply that need?

*Joel Chandler Harris*

From a Harris Editorial in Henry Grady's *Sunday Gazette*  
October 5, 1878

## QUOTES

*The heart of another is a dark forest, always, no matter how close it has been to one's own.*  
WILLA CATHER

*The only function of economic forecasting is to make astrology look respectable.*  
EZRA SOLOMON

*Fine words butter no parsnips.*  
ENGLISH PROVERB

*I think people should go into public office for a term or two, and then get back into their businesses and live under the laws that they passed.*  
MIKE CURB

*The general remedy of those who are uneasy without knowing the cause is change of place.*  
SAMUEL JOHNSON

*Little progress can be made merely attempting to repress what is evil. Our great hope lies in developing what is good.*  
CALVIN COOLIDGE

*Man is not the creature of circumstances, circumstances are the creatures of man.*  
BENJAMIN DISRAELI

*Probably no man ever had a friend he did not dislike a little; we are all so constituted by nature no one can possibly entirely approve of us.*  
E. W. HOWE

*When once a decision is reached and execution is the order of the day, dismiss absolutely all responsibility and care about the outcome.*  
WILLIAM JAMES

*Money is as money does. If it doesn't, it isn't.*  
EDWARD SMITH

*Women love men for their defects, if men have enough of them women will forgive them everything, even their gigantic intellects.*  
OSCAR WILDE

*It saves a lot of trouble, instead of having to earn money and save it, you just go and borrow it.*  
WINSTON CHURCHILL

*Do men like to fish or do they just like to get away from it all?*  
WILLIAM FEATHER

*I am a great friend to public amusements, for they keep people from vice.*  
SAMUEL JOHNSON

*Money is power, freedom, a cushion, the root of all evil, the sum of blessings.*  
CARL SANDBURG

*Men always want to be a woman's first love — women like to be a man's last romance.*  
OSCAR WILDE

*Natural forces within us are the true healers of disease.*  
HIPPOCRATES

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

## **\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** requires that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army.

The Bonus Test Program is scheduled to begin on or about August 1, 1989 and will be offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test will offer \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM**

**PLEASE CONTACT:**

**ARMY RESERVE HEALTH CARE TEAM**

**BLD 710/FIRST FLOOR, FT. GILLEM, FOREST PARK, GA 30050-5000  
OR CALL: (404) 362-3374 COLLECT**



## *Lyme Disease — The Great Imitator*

Joseph P. Bailey, Jr., M.D., James H. Oliver, Jr., Ph.D.

**A** DISEASE WHICH WAS KNOWN at the turn of the century in Europe, but not defined then as to mode of transmission and etiology has, within the past 15 years, become clearly a problem of worldwide concern. In the United States, Steere was the first American to recognize the importance of this disease in 1977, although at that time he thought it was "new disease." He named it Lyme Arthritis after the Connecticut town where it was found and because of its musculoskeletal manifestations. Later, because of other body systems' involvement, its name was changed to Lyme disease. Two years later, Spielman described a new tick species, *Ixodes dammini*, which was later found to be the vector of the disease. Subsequent identification of the etiologic agent, *Borrelia*

**‘The two articles that deal with Lyme disease which appear in this issue of the *Journal* will help clarify information concerned with the clinical and epidemiologic aspects of this disease.’**

*burgdorferi*, in the gut of the tick by Burgdorfer followed in 1982.

The disease state is complicated by the difficulty in culturing the causative organism and by the lack of standardization of laboratory studies to aid in the diagnosis and therapy of Lyme disease. Additionally, there may be incomplete clinical presentation of this disease generating diagnostic confusion. Presently, treatment and its effectiveness appear to relate to how soon treatment begins after the tick bite. Studies of large numbers of patients over prolonged periods of time are lacking, and thus results of late stage treatment are inconclusive. Understanding Lyme disease will require multi-faceted efforts.

The two articles that deal with Lyme disease which appear in this issue of *Journal* will help clarify information concerned with the clinical and epidemiologic aspects of this disease. Cooperative efforts are needed to evaluate the potential exposure of the population of our state to ticks and Lyme disease. We need to know which tick species serve as vectors and which vertebrate species serve as reservoir hosts to the spirochete and ticks in Georgia. What percentage of ticks actually carry the spirochete?

Also of great importance are the possibilities for controlling the

**‘The character of the immunogenic determinants of *Borrelia burgdorferi*, the nature of the immune response to its presence, and the histopathology of the disease in various stages are but a few of the unknowns of Lyme disease requiring investigation.’**

tick vector and by virtue of such, possibly decreasing or eradicating the exposure of the human population to this spirochete. Preventing tick bite is obviously the best method of protection. A vaccine against ticks or Lyme disease is not likely in the near future. Moreover, Lyme disease is a zoonosis, largely a disease of nonhuman animals, and as such can never be eliminated by

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treatment of only humans. Some of these issues are discussed in the two articles in this *Journal*.

As will be pointed out, there is a possibility of cross-reactivity between certain sera with the test system antigen for *B. burgdorferi*. The presence of a positive serologic response, therefore, cannot be used alone to prove the presence of disease, nor for that matter previous exposure to *B. burgdorferi*.

Much work is required to understand the bacterial factors related to virulence and colonization of *B. burgdorferi* and to develop an improved culture medium for the organism. The character of the immunogenic determinants of *B. burgdorferi*, the nature of the immune response to its presence, and the histopathology of the disease in various stages are but a few of the unknowns requiring investigation, as suggested by the National Institutes of Health.

**‘Lyme disease is now the most frequently reported vector-borne disease in the United States. From 1983 through 1987, it represented approximately 50% of all vector-borne disease cases.’**

**I**n Georgia, indeed, the entire United States, Lyme disease is now the most frequently reported vector-borne disease. From 1983 through 1987, it represented approximately 50 percent of all

**‘Georgia’s DHR reported 107 cases through June 23, 1989. From that date through August 8, 1989, the total number of reported cases grew to 299.’**

vector-borne disease cases in the U.S. Currently, its incidence is even greater. The Georgia Department of Human Resources reports increases in Georgia from 4 cases in 1987, to 59 cases in 1988, and 107 cases through June 23, 1989. The DHR now considers the disease endemic in Georgia, and cases have been reported from 87 counties scattered throughout the state.<sup>1</sup> From June 23, 1989, to August 8, 1989, the total number of cases reported grew to 299.<sup>2</sup> There have been 531 positive serologies of 2,372 tested sera as of July 31, 1989.<sup>3</sup> Clearly, much is known, but there is a tremendous amount yet to be learned. All of us should be cautious in our approach to this problem and maintain an open, investigative, intelligent, and compassionate concern that is the hallmark of good medical care.

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3. Personal communication with Marsha Ray and J. David Smith, Georgia Department of Human Resources, August 8, 1989.

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## *How Aggressively Should We Treat Very Sick and/or Immature Babies?*

*Kenneth C. Henderson, M.D.*

**‘ There is never a problem starting care in a patient if there is any chance for survival . . . The problem we have as physicians is withdrawing care that is not helpful and potentially harmful. ’**

**H**AVE WE REACHED our limit in caring for very immature babies? The question seems to be coming up more and more these days. Are our limits based on lack of knowledge, technology, or financial support? Can we do more as dedicated health care professionals or, in fact, should we do more to promote life? Neonatologists are bombarded by such ethical and moral dilemmas daily with no relief in sight.

### **How Small Is Small?**

Head growth of less than 22 cm is small. These babies are usually less than 24 weeks gestation and weigh 500 grams or less. Birthweight of 500 grams or less or gestational age of less than 24 weeks is small. The survival rate for these babies is 5% or less. The survival rate in the Intensive Care Nursery at the Medical Center of Central Georgia over the past 15 years is 5% for babies weighing between 500-600 grams. During that time, we have had over 4,000 admissions. All babies with a heart rate or that can be resuscitated in the delivery area are admitted.

### **Experimental Care**

Our survival at 750 grams is approaching 50%. I believe most physicians would agree that care with less than a 50% success rate could be termed experimental.

The care we provide babies under 750 grams birthweight would fall into the experimental category. We must be honest with ourselves when confronted with each patient care situation. Experimental care should not be provided in an area where it can not be adequately studied.

### **Inborn vs. Outborn Babies**

Inborn babies do better than outborn babies unless one is dealing with a very selected population. This may be due to better prenatal care, obstetrical care, or better condition of the baby at birth. Certainly all would agree that the mother is the best transport vehicle for the baby. She should be moved to a tertiary center for delivery when she can be identified as high risk. The great majority of high-risk pregnancies are high risk for the baby. We are presently moving too many immature babies around the state in ambulances and helicopters.

### **Starting and Stopping Care**

There is never a problem starting care in a patient if there is any chance for survival even if the baby is less than 500 grams or

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**‘The great majority of high-risk pregnancies are high risk for the baby. We are presently moving too many immature babies around the state in ambulances and helicopters.’**

has a head circumference of less than 22 cm. The problem we have as physicians is withdrawing care that is not helpful and potentially harmful. The current medical-legal climate may have caused many physicians to give up their cultural authority when treating patients. Some of us are providing care for patients we would not choose for ourselves or our family. When the number of lawsuits resulting from continuing care equal those for discontinuing care then physicians may regain their authority and justified respect by once again doing what is best for the patient. There seems to me to be very little legal risk to physicians who provide hospice care to appropriate patients. Physicians should not feel obligated to move babies to tertiary centers for hospice care.

## Truth in Advertising

Physicians born and raised with great technology seem to give it the same reverence as do patients. Our knowledge is very limited. Life and death is in fact still not up to physicians. False hope prolongs grief and interrupts the grieving process. Knowing our limitations as physicians may be the beginning of wisdom.

## Cost Considerations

Every baby should be given a chance for survival. It is not prohibitively expensive to initiate care. Most babies (50%) weighing 500-750 grams that die do so in the first 24 hours of treatment. Survivors may cost in excess of \$100,000. The good news is that evidence is accumulating showing survivors of birthweight below 1,000 grams have the same prognosis as babies with birthweight of 1,000 to 2,000

grams. Both groups have a 10-15% severe handicap rate.

Providing ineffective care may have a harmful effect of patient care in the intensive care unit. The sickest patients with the worst prognosis consume an inappropriate share of people and financial resources. The culture of the unit suffers when more than 33% of patients present impossible ethical dilemmas.

In the past we have accepted mothers for delivery with previable babies and accepted previable outborn babies. We have accepted such patients in an effort to accomplish our role as a tertiary referral center. Cost considerations may prevent us continuing this service to our referral physicians. Funds are not presently available to treat patients we know we can benefit.

## Management Considerations

Our number one goal must be the prevention of prematurity. There are no easy solutions to this formidable challenge. The issues of birth control and abortion seem to have no acceptable or manageable solution. We are the only industrialized nation that has no system to provide universal prenatal care. As a kinder and gentler nation we can do better. All high-risk mothers must be afforded a safe environment for the delivery of their baby. The funding level of 30% of cost must be improved if our five-state designated Intensive Care Nurseries are to financially survive. We must also have increased funding to improve our infant follow up to more effectively evaluate our treatment and protect the graduates of our units. ■



## *Aggressive Treatment: Who Decides?*

Betty Castellani

***“When a patient has been presented with all the facts and has received input from many knowledgeable sources but still chooses not to be treated, a physician should respect that decision no matter what his or her personal opinion may be.”***

**E**THICAL TEXTBOOKS present the dilemma of the scarce medical resource and the question of which candidate should benefit from it: the youngest, the most educated, the parent with the young child, the research scientist on the brink of discovery, or the candidate who is the sole support of 15 people. These textbooks rarely provide an answer because to date we have no reliable guidelines for determining the value of human life. Usually the philosophers suggest pulling a name out of a hat.

Fortunately, for most physicians the scarce resource dilemma is rarely the issue. The issue physicians more commonly face is how aggressively should a particular patient be treated. This decision also has life and death consequences. What criteria are generally used as the determining factors for an individual patient? Who makes that decision?

Most physicians would present criteria for aggressive treatment such as age, general health, quality of life, the potential benefit of treatment, the patient's overall prognosis, and the cost factors involved. Indeed, doctors are often required to make moral decisions and critical choices with no real certainty as to how an illness will effect a particular patient or how that patient will respond to a given treatment.

No matter what criteria are

used, however, there are always contradictions. When we use age, we remember that Verdi wrote “Ave Maria” at 85. When we choose quality of life, we are reminded that Stephen Hawking, author of the remarkable book *A Brief History of Time*, portrays all the attributes of the Renaissance Man in spite of the wasted and twisted body he occupies as a result of ALS. When we think prognosis, every doctor knows a patient who should have died based on the medical circumstances but who got well and went home instead. Statistical results are liberally quoted, but few can predict which patients can beat the statistical odds. Some always do. Thus, the criteria we select are rarely reliable for every patient.

Because of the lack of acceptable, reliable criteria for deciding on who should be aggressively treated, a doctor need not feel obligated to assume the burden of this decision. In treating the *competent*<sup>1</sup> patient, that patient has the right to choose how aggressive the treatment protocol should be.

**A** review of the literature is clear on this issue. Courts have established the patient's freedom to choose on several rationals: the patient's unique

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evaluation of what is in his or her own overall best interest, the patient's right to control his or her own body and to protect his or her own bodily privacy, and the patient's right to exercise his or her own religious convictions.<sup>2</sup>

***“There is a great need for the public to be educated on the ethical problems presented by modern medicine.”***

If a patient is competent, he or she has a moral and legal right to make his or her own decisions about acceptance or rejection of treatments of all kinds. These decisions take precedence over the wishes of physicians or family members.<sup>3</sup> The patient should be presented all available information and options for his or her care and should be empowered to decide treatment. The physician should acquiesce to the wishes of the patient or withdraw from the case.<sup>4</sup>

Conflicts for physicians occur in two instances. First, the physician wants to treat the patient and believes the treatment will significantly benefit the patient but the patient refuses to consent to treatment. Physicians trained to heal have an extremely difficult time accepting such decisions.

There are many reasons patients choose not to be treated: (1) Either the patient's life has never worked or they have problems or emotional pain they cannot resolve and death by disease is a respectable way out. Doctors are rarely privy to this information. (2) The best result of a treatment presents some patients with a quality of life they find unacceptable, even though

the majority of patients would be content, even thankful. (3) The patients' religious beliefs govern their decision. (4) The patient is not willing to subject him or herself to additional pain and suffering regardless of the potential benefit. (5) The likelihood of a good outcome is too small in the patient's opinion to justify the treatment. (6) The patient cannot overcome his or her fear and conviction that the situation is hopeless.

When a patient has been presented with all the facts and has received input from many knowledgeable sources but still chooses not to be treated, a physician should respect that decision no matter what his or her personal opinion may be.

**T**he second dilemma occurs when a physician does not feel that aggressive treatment would significantly benefit the patient but the patient insists on being treated. Here again, it is important for the physician to look at the patient and not the disease. Physicians must be especially careful to avoid decisions not to treat that are based on their own value systems or on their evaluation of the quality or burden of the patient's life or the value of the patient to society.<sup>3</sup>

Many physicians cannot see the benefit of treating a patient with a very poor prognosis, particularly when the treatment will subject the patient to greater suffering. However, for some patients the emotional pain of doing nothing and the hopelessness which decision implies makes daily life intolerable. The thread of hope treatment offers for them makes life more bearable and thus the quality of life more enjoyable. Their wishes should be respected.

Often, these patients are true survivors, and some do overcome the odds against them. That small thread of hope should not be denied them.

Physicians should make it a practice to arrange some private time with each patient to ascertain the patient's wishes for treatment. Family members should not decide for the patient; often patients are put in the position of having to agree to treatment because of pressure from family members. If a doctor understands the patient's preference, he or she can assist the patient in carrying out that preference.

In many cases, patients rely heavily on their physicians in the decision-making process. Studies have shown that the healthy population prefers that the decision making be a joint venture between the physician and the patient, but the sicker a patient becomes, the less interested they are in participating in treatment decisions.<sup>5</sup>

Many patients are so immobilized by fear when serious illness occurs that they are incapable of making critical decisions. They trust their doctor to make treatment decisions for them emotionally and physically until they are able to get control of their circumstances. The physician should take special care to identify this type of patient and treat him or her with gentle hands.

**A**ggressively treating the incompetent patient is still an unresolved legal, medical, and moral dilemma. The simple answer is to use some surrogate mechanism that would come as close as possible to representing the patient's viewpoint, not the viewpoint of the surrogate or the



physician. When there is any doubt about what the patient would want, the patient should be treated.<sup>3</sup> Physicians are urged to approach this type of situation with great caution. The literature on the issue of treating the incompetent patient reflects the genuine unresolved dilemma that exists in the legal/medical arena.<sup>2</sup>

**T**here is a great need for the public to be educated on the ethical problems presented by modern medicine so that when a family faces such an issue they will have some knowledge on which to base their treatment decisions.

What about economic considerations in determining whether or not a patient should be aggressively treated? Should a physician consider the broad question of the prudent use of medical resources in prescribing aggressive treatment?

The physician should respect the wishes of the patient who is ill. The allocation of our costly medical resources is important, but this issue must be decided in the arena of national health care decision-making,<sup>6</sup> not at the bedside of the individual patient. The right of the competent individual to choose or refuse treatment should remain a personal, private right.

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## *The Strongest Man on Earth*

*Alfred A. Messer, M.D.*

**A** PERSONAL OPINION: the strongest man on earth is retired Air Force doctor, Colonel John Paul Stapp. Anyone who read *Life* magazine during the 1950s remembers his picture on the cover, showing his participation in acceleration/deceleration experiments.

Col. Stapp was strapped into a rocket-propelled sled, and after the charge was ignited, the sled zoomed to land speed records of 632 miles per hour. Then retro-rockets were fired and the vehicle brought to a stop in seconds. His body parts didn't slow that quickly, and dramatic photos showed his eyes bulging ahead out of their sockets, his face contorted as the cheeks and soft tissues were drawn forward, his shoulders straining against the encasing harness.

Then there were a series of experiments to study physiologic response in high altitude conditions. Specifically, what were the effects on the body of high-speed wind blasts, such as might be encountered in bailing out of a jet aircraft? Col. Stapp was flown to altitudes of 40,000 - 50,000 feet, where he would bail out. He lost consciousness, but a triggering device opened his parachute as he fell. He regained consciousness as he descended to an atmosphere where there was sufficient oxygen.

While all of these experiments were in progress, telemetry devices recorded

electrocardiograms, blood pressure readings, body temperature and respiration.

In a word, Col. Stapp led us into the Space Age by putting his body on the line to learn the physical and mental effects of gravity and acceleration/deceleration. He himself endured acceleration forces of 35 g's, nearly twice the force assumed to be the human limit.

Col. Stapp was no slouch academically either. He obtained three college degrees at Baylor before he took a Ph.D. in physics at Texas, an M.D. at Minnesota, and a D.Sc. degree in industrial medicine at New Mexico.

All of us respond to new challenges in our own way, and a part of America's ethic since its founding has been pushing out to new frontiers. But what motivates a person to push to the levels achieved by John Paul Stapp? Is it more than scientific curiosity?

**A** clue comes from the study of his background. He was born in Salvador, Brazil, the son of American missionary parents. From the earliest moments of his life, his parents stressed, "We are strangers here, and white. To the natives, we're Yankees. We must never let anyone see us weak or afraid or foolish. We must always be strong."

There are legends about young Stapp's feats as a child, leading trips and surviving in the jungle. As an adolescent, he

could run rapids and fight off wild animals as adeptly as any grown man.

**I**t is fair to speculate that he learned this lesson ("be strong") well, and the message was a compelling force throughout his life. He performed heroically in the military, and after leaving the service, he studied survival in auto crashes at the National Highway Safety Bureau from 1967 to 1973. Society has benefitted greatly from Col. Stapp's life work. Manned space exploration is safer because of him.

Most career counsellors agree that parents are the source of greatest influence in children making choices about adult vocations. Sometimes the message is direct ("We want you to be a musician"). Or, more subtle, ("Of all our friends, don't you admire the teacher the most and wouldn't it be nice to be just like him/her?").

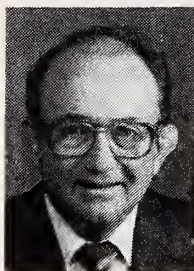
But career choice is a gradual process, a merging of aptitude and contentment, a desire to please oneself as well as one's parents. For Col. Stapp it was incorporation of a parental value alongside the need to meet and conquer new challenges. As he wrote about himself, "I live in hopes of doing better and producing more." ■

Dr. Messer practices psychiatry. His address is 3332 Valley Rd., Atlanta, GA 30305.

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# Lyme Disease: Tick Vectors, Distribution, and Reservoir Hosts

James H. Oliver, Jr., Ph.D.

**L**YME DISEASE is an important malady, sometimes difficult to diagnose, and apparently spreading geographically.<sup>1</sup> Records provided by the Georgia Department of Human Resources indicate an explosive increase in number of cases in Georgia; this seems to be the pattern in most of the United States.<sup>2</sup> The question arises as to how many of the cases are due to increased prevalence of the disease and how many are due to better recognition. Probably both factors play a role. Although the future is uncertain, it seems likely that Lyme disease will become more prevalent for a variety of reasons.

Almost certainly the disease has existed in Europe and Asia for centuries. Less certain is the length of time it has been present in North America. Clearly, however, it has been here for much longer than 1970 when it was first recognized.<sup>3</sup>

The editorial<sup>4</sup> and the article by Bailey, et al.<sup>5</sup> about Lyme disease appearing in this issue of the *Journal* provide some information regarding the history and background of this important disease. Thus, these aspects will not be presented here.

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**Increased funding of research on Lyme disease is imperative if we are to reduce the threat of this disease, improve diagnostic procedures, and discover better regimens of treating patients.**

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## Acquisition and Transmission

Lyme disease is caused by the spirochete *Borrelia burgdorferi* when an infected tick transmits the spirochete to an uninfected host. The tick (several species of the *Ixodes ricinus* species complex) can acquire the spirochete as a larva, nymph, or adult. Larvae and nymphs can pass it to the next developmental stage (transstadial transmission). Upon feeding during the next stage, it often transmits some of the spirochetes to the host

and also may receive spirochetes if that host is already infected. Trans-ovarial transmission (passing the spirochete from infected female ticks via the eggs to the larvae) is lower in *I. dammini*<sup>6,7</sup> and *I. pacificus*<sup>8</sup> (probably 1-2%) than *I. ricinus* (80%).<sup>9</sup>

**I**n nature, the usual scenario is for uninfected larvae to feed on infected mice, molt to the nymphal stage; the infected nymph then transmits the spirochetes to the second host. Upon feeding, the nymph molts and remains infected as an adult. Both nymph and adult ticks are effective vectors of the spirochete, but the nymph is usually the stage that most frequently transmits the spirochete to humans because it is so small that most persons do not notice it. Adult ticks are larger and are usually observed and removed. Ticks must remain attached to a host for a minimum of 24 hours before transmission and subsequent disease occur.<sup>10</sup>

## Lyme Disease as a Zoonosis

To understand Lyme disease in humans, one must understand it in other animals. It is a zoonosis that

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has been circulating in nonhuman species probably for a long time. Humans are only accidentally brought into the cycle when a vector-competent tick attaches to them. Thus, Lyme disease is similar to other zoonoses such as toxoplasmosis, leptospirosis, Ehrlichiosis, rabies, etc., in that most of the etiologic agents are in wildlife and are not normally transmitted among humans. This fact has profound importance when considering strate-

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**Preliminary results indicate that in Georgia, the black-legged tick *Ixodes scapularis* is the prime vector of the spirochete *Borrelia burgdorferi*, which causes Lyme disease.**

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gies of prevention to humans. The infectious agents, the spirochete *B. burgdorferi* in the case of Lyme disease, can never be eliminated by treatment of only humans. In fact, even the elimination of wild animal reservoir hosts would not solve the problem. The tick vector also maintains the spirochete transstadially from the larvae through the nymphs to the adults. The impossibility of treating all infected humans, reservoir wild and domestic animals, and elimination of ticks (and doing this simultaneously) means that Lyme disease will be a constant threat. It is likely to spill over into the human population whenever humans enter the complex natural host-parasite-vector cycle in nature.

**T**he tick vector is the crucial factor in the Lyme disease equation in human and other species. But how can we eliminate the tick population without enormous expense, and more importantly, without severely damaging the environ-

ment? Moreover, some would argue that total elimination of ticks is neither a desirable nor achievable goal. In any event, large scale spraying of acaricide would have a major environmental impact on other organisms, including humans. Other widespread control strategies suffer the same problem — simply put, the target ticks are too well dispersed.

All is not gloom and doom, however, if we focus on regional or site control of the vector tick species. To do this in an intelligent manner requires that we identify which of the 850 species of ticks are vector competent, and then learn the secrets of their nature. Once the secrets are known, a combination of integrated methods (acaricide spraying, biologic control techniques including genetic control, host reduction, and habitat alteration) can be employed effectively to reduce tick vector populations below a critical minimum number. How much do we know about the tick vectors of Lyme disease, their geographic distribution, reservoir hosts of the spirochetes, and hosts of the ticks? The answer is much, but not enough. Much more research is needed.

**I**n the meantime, persons will have to depend on self protection and perhaps alter their behavior. Wearing light-colored clothes is recommended when engaging in activities in nature so that ticks can be seen as they move about. Long pants and long-sleeved shirts are desirable and socks should be pulled over the cuffs of trousers. An insect repellent containing deet or permethrin may be applied; the instructions for use of these chemicals should be carefully followed. Frequent body searches for ticks should be made and upon return from the field a thorough check of the entire body and a shower are advisable.

If a tick is found attached and feeding, it should be removed immediately with fine-tipped tweezers. The tick should be grasped as close to the skin as possible, and with a steady movement, pulled straight out in the direction it is ori-

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**Infected ticks rarely transmit the disease in less than 24 hours.**

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ented. Pulling in a different direction might result in breaking off its skin. After the tick is removed, it should be placed in a vial of alcohol so that it can be identified by an expert. *This is extremely important!* An antiseptic should then be applied to the tick bite site to prevent secondary infection. Heat, vaseline, butter, mineral oil, fingernail polish, etc., should not be applied to facilitate tick removal — these are ineffective and might kill the tick and result in its remaining attached. Remember, infected ticks rarely transmit the disease in less than 24 hours.

If the tick is identified as one of the vector-competent species, a physician should be consulted. Antibiotics *may* be recommended even in the absence of symptoms under certain circumstances, such as during pregnancy. Otherwise, it is probably prudent to wait and see if symptoms of Lyme disease appear before treating. Unfortunately, many Lyme disease patients do not remember being bitten by a tick. This is particularly true when the tiny nymph is the vector.

#### **Vectors of Lyme Disease**

It appears that the primary vectors of Lyme disease all belong to a single tick species group, the *I. ricinus* complex (*I. ricinus* in western and central Europe, *I. persulcatus* in Asia, and *I. dammini*, *I. scapularis*, and *I. pacificus* in North America). Little is known about the vectors in Africa and Australia. More is known about the North American vectors, and a great deal is known about the European and Asian vectors. Members of the *I. ricinus* complex are not the only ticks, however, from which *B. burgdorferi* has been isolated. The spirochete has been found also in several other tick species and even in some deer flies clude *Dermacentor variabilis*, *D. albipictus*, *Amblyomma ameri-*



*canum*, *I. dentatus*, *I. cookei*, *I. trianguliceps*, and *Haemaphysalis leporispalustris*. Most of these species do not play a significant role in transmission and are probably poor vectors. The mere isolation of an infectious agent from a blood-feeding arthropod proves little more than that it has recently fed on infected hosts. One must be cautious, however, before ruling out transmission by such an arthropod until adequate experimentation has been completed. The critical experiments have not been conducted in most of the above noted species; however, epidemiologic and host preference data suggest that except for the *I. ricinus* species complex, the other species probably are not important from a public health standpoint.

Interestingly, because of the zoonotic nature of Lyme disease, *I. trianguliceps* in Europe and *I. dentatus* in the United States might serve as vectors of *B. burgdorferi* among the small mammal populations. Although these ticks do not feed on humans, they might be very important in maintaining the spirochete in nature. Thus, when the less host-specific *I. ricinus* and *I. dammini* feed on infected small mammals, they acquire the spirochete and may subsequently pass it on to humans.

*I. dammini* (the deer tick) is responsible for more human cases of Lyme disease in North America than any other species. *I. pacificus* (the western black-legged tick) ranks second in number of transmitted human cases. *I. scapularis* (the black-legged tick) is almost certainly the primary vector in the southern United States, although not enough field research has been completed to prove this unequivocally. In the laboratory, no difference was observed between it and *I. dammini* regarding vector ability.<sup>11</sup> Moreover, the question arises as to whether, in fact, *I. scapularis* and *I. dammini* are separate species. Unpublished data from my laboratory indicate no barrier to hybridization between them, no difference in chromosomes, no difference in host preference,<sup>12</sup> and

similarities regarding several aspects of their ecology and biology. It is important to note that for purposes of identification the ticks of the *I. ricinus* species complex are significantly smaller than the American dog tick, *D. variabilis*.

#### Distribution of Lyme Disease and Tick Vectors in the United States

The northeastern United States has the dubious honor of being the greatest focus of Lyme disease, but many cases have also been identified in the northcentral part of the United States especially Minnesota, Wisconsin, and from California. Recently, as noted, large increases in numbers of Lyme disease cases have occurred in Georgia. The disease has been found in at least 43 states, and it seems only a matter of time until it is reported from all 48 continental states.

Again the question arises as to how many of the new cases are due to better recognition and how many are due to actual spreading of the disease. Recent publicity and education no doubt account for better recognition, but the tick vectors, especially in eastern North America, appear to be increasing in numbers and geographic range. Clearly, the deer population in eastern North America has been increasing at an accelerated rate during the last 2 decades, and deer serve as the principal host for the adult stage of the vector ticks.<sup>13</sup> Many ticks can feed on each deer, and each *Ixodes* female produces approximately 2000 eggs. Thus, deer serve as one of the chief tick amplifying hosts. Fortunately, although whitetail deer play a large role in increasing tick numbers and can be infected with the spirochete, they apparently do not serve as a reservoir host for the spirochete.<sup>14</sup>

The main reservoir host for the spirochete in the northeast is the white-footed mouse, *Peromyscus leucopus*,<sup>15</sup> which also appears to be one of the favorite hosts for larval and nymphal *I. dammini*.<sup>16</sup> A similar host-spirochete-tick equation occurs in the western U.S., except that the chief vector is *I. pacificus*.<sup>17</sup> As noted, in Georgia and

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**The tick vector is the crucial factor in the Lyme disease equation in human and other species. Some would argue, however, that total elimination of ticks is neither a desirable nor achievable goal.**

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the southeastern U.S., *I. scapularis* is almost certainly the principal vector, and the cotton mouse (*P. gossypinus*) is probably one of the main reservoir hosts to the spirochete.

There is a lively debate regarding reservoir hosts to *B. burgdorferi*. Many mammals and birds harbor this spirochete,<sup>18, 19</sup> but it is unclear how many of them maintain the spirochete at a level sufficient to serve as an infectious meal to ticks. The identification of antibodies to *B. burgdorferi* in hosts simply means that the host has been exposed to *B. burgdorferi* (or one of the microorganisms which cross-react serologically with it). Additional data are needed before one can conclude that the seropositive host is serving as a bona fide reservoir host.

Tick hosts serve not only to increase tick populations and sometimes provide infectious blood meals but also to transport ticks to new geographic areas. If the spirochete accompanies the tick or follows it later, then the distribution of both tick and spirochete is expanded. Distribution of tick and/or spirochete via small mammals and even deer is relatively slow, but birds can transport ticks many miles in a short period of time and have been found infested with *I. dammini*.<sup>19, 20</sup> Also, pets that accompany owners on vacation, etc., serve as an excellent means of tick distribution as does shipment of livestock and wild animals for hunting purposes.



## Conclusions

Lyme disease has been reported in all but five of the continental United States and is probably present in all of them. The area of highest density of cases remains the northeastern United States, but physicians in all regions should be prepared to consider Lyme disease in patients when history of tick bite and/or symptoms of Lyme disease are present.

Georgia is now considered endemic for Lyme disease. A total of 299 positive and 84 probable cases have been reported by the Georgia Department of Human Resources in the first 7 months of 1989. These originated from 87 counties scattered throughout the state. Preliminary results indicate that in Georgia, the black-legged tick *I. scapularis* is the prime vector of the spirochete, *B. burgdorferi*, which causes Lyme disease. *B. burgdorferi* appears to be spreading.

**L**yme disease becomes a problem to humans when a critical threshold of spirochetes, reservoir hosts, and number of competent vector ticks is exceeded, and humans venture into their domain. Vaccines against ticks and *B. burgdorferi* will not be available in the near future. Thus, prevention of tick bites and early antibiotic treatment of human cases are the best strategy for prevention at this time.

Increased funding of research on Lyme disease is imperative if we are to reduce the threat of this disease, improve diagnostic procedures, and discover better regimens of treating patients, especially those at the intermediate and chronic stage of the illness. The long-term effects of the disease are not known but are a

**Both nymph and adult ticks are effective vectors of the spirochete, but the nymph is usually the stage that most frequently transmits the spirochete to humans because it is so small that most persons do not notice it.**

source of concern because of some similarities between Lyme disease and syphilis, another spirochete-induced malady.

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# Clinical Aspects of Lyme Disease

Joseph P. Bailey, Jr., M.D., Samuel D. Brown, M.D., Richard S. Field, M.D., Donald H. Loebel, M.D., Thomas C. McGee, M.D., Henry G. Mealing, Jr., M.D.

**T**HE OCCURRENCE of a tick bite with transmission of *Borrelia burgdorferi* to the human being may be followed by clinical illness. The tick must remain attached to the skin for 24 hours to allow for transmission of the spirochete. The early treatment of this infection may alter the disease course and subsequently prevent the occurrence of the intermediate and late stages of the disease. The disease previously described by Steere<sup>1</sup> in patients in Lyme, Connecticut, was further characterized by isolation of the spirochete by Burgdorfer<sup>2</sup> from one tick vector, *Ixodes dammini*. It is now known that at least four other ticks may also serve as carriers for the spirochete. The previous localization of the disease to the Northeast has been followed by increasing reports of cases from at least 43 states.<sup>3</sup> In Georgia, the serologic evidence for immune response to *B. burgdorferi* has increased, and the Georgia Department of Human Resources Laboratory has now reported some 318 positive studies out of 2,372 studies on July 28, 1989.<sup>4</sup>

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**The early treatment of this infection may alter the disease course and subsequently prevent the occurrence of the intermediate and late stages of the disease.**

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## Clinical Manifestations By Stage

The clinical disease usually manifests its first stage in 1 to 4 weeks following a tick bite and introduction of the spirochete into the human being. The most helpful diagnostic finding is the presence of the skin lesion which has been named Erythema Chronicum Migrans or Erythema Migrans. This in classic form is an expanding circular erythematous lesion (median 15 cm in diameter). The center of the lesion may demonstrate partial clearing. Satellite lesions may appear. Other less classic lesions may be present, or there may be *no* skin

manifestation at all. Associated with dermatologic manifestations there are usually "flu-like" symptoms of malaise, myalgia, arthralgia, and headache. These findings may last several weeks, usually 3 to 4, and may disappear with or without treatment.

**T**he second stage of the disease may begin several weeks or months after the initial infection and manifest as cardiac and neurologic involvement. The cardiac involvement may be life threatening as noted by varying degrees of heart block and myopericarditis. Once having cleared, these cardiac changes do not usually return. In contrast, the neurologic disease may persist for months and can present as aseptic meningitis, encephalitis, and cranial and other peripheral neuropathies. Bell's palsy is a common peripheral manifestation and may be bilateral. Other neurologic changes include plexitis, optic neuropathy, and myelitis. The course of neurologic involvement may last several weeks or years.

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**Erythrocyte sedimentation rates are usually elevated, and some patients have demonstrated microscopic hematuria and mild proteinuria in the presence of normal creatinine and blood urea nitrogen.**

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The third stage of Lyme disease presents weeks to years after the initial onset of illness; arthritis is its major manifestation. This occurs in 50-60% of patients. Usually the arthritis involves large joints, particularly the knee, is monoarticular or asymmetrically oligoarticular, and initially intermittent. In a small number of patients, arthritis may become chronic and rarely may involve erosion of cartilage and bone or permanent joint disability. A symmetric polyarthritis may also be seen resembling classic rheumatoid arthritis.<sup>5</sup> Stage 3 neurologic disease can mimic CNS tumors, multiple sclerosis, and psychiatric-related illness, including Alzheimer's disease.<sup>6</sup> The onset of the third stage may be as early as several days and up to 2 years, with a mean of 6 months after initial onset of disease. It may last indefinitely. There is evidence supporting congenital infection with *B. burgdorferi* and adverse fetal outcomes.<sup>7</sup>

#### Laboratory Studies

Laboratory findings in Lyme disease have been of value. Usually rheumatoid factor is not found, nor antinuclear antibodies. Erythrocyte sedimentation rates are usually elevated, and some patients have demonstrated microscopic hematuria and mild proteinuria in the presence of normal creatinine and blood urea nitrogen.<sup>5</sup> Anticardiolipin antibodies have been reported in association with neurologic changes and were related to the IgM response.<sup>8</sup>

Synovial fluid findings reveal increased white blood cell counts av-

eraging 25,000 cells per mm.<sup>3</sup> Most of these cells are polymorphonuclear leukocytes, but synovial fluid eosinophilia has been reported.<sup>9</sup> The synovial fluid C3 level may be low compared to serum. Synovial biopsies may histologically resemble those from patients with rheumatoid arthritis.<sup>5</sup>

There has been a low yield in obtaining organisms for direct visualization and for culture in patients with Lyme disease. Therefore, considerable reliance has been placed on the determination of antibodies to the spirochete, *B. burgdorferi*. The initial immune response is in the IgM class and reaches a peak between 3 and 6 weeks from the onset of disease. IgG antibodies rise slowly and are highest months or years after the onset of the disease.<sup>5</sup>

**T**he laboratory test systems usually involved are immunofluorescent assay (IFA) and the enzyme linked immunoabsorbent assay (ELISA).<sup>10</sup>

The IFA uses the principle of indirect immunofluorescent evaluation and can be performed using polyvalent (anti-IgM and anti-IgG) sera for screening purposes or more directly using monospecific anti-human IgM and IgG fluorescein labeled antisera. A titer of 1:256 or greater is considered positive with the polyvalent system, while usually 1:16 with IgM and 1:128 with IgG is considered positive. These systems use the spirochetes bound to a slide as antigen.

The ELISA for Lyme uses an extract of the spirochete bound to an assay well, and the patient's serum is added. The antisera to human immunoglobulin is conjugated with alkaline phosphatase, and the subsequent colorimetric change is measured. The two test systems appear to be equally sensitive.

False-negative tests can occur early in the disease and in antibiotic-treated disease. False-positive results can occur in the case of other spirochetal diseases, including syphilis. In Lyme disease, the VDRL has been negative. False-positive tests have also been reported with relapsing fever (*B. hermsii* and *B. recurrentis*), rocky

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**The most helpful diagnostic finding is the presence of the skin lesion which has been named Erythema Chronicum Migrans or Erythema Migrans. Other less classic lesions may also be present, however, or there may be no skin manifestations at all.**

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mountain spotted fever, and leptospirosis. Also included in producing false-positive reactions are infectious mononucleosis, systemic lupus erythematosus, and rheumatoid arthritis.<sup>11</sup>

#### Lyme Disease Symptoms as Imitators

When ECM is present in its characteristic form, there is practically nothing with which it may be confused. However, atypical skin involvement in Lyme disease is not uncommon. If ECM is present in non-expanding form, it may be mistaken for a non-infected insect bite. Secondary skin lesions may be confused with erythema multiforme, erythema marginatum, or the rash associated with Hepatitis B infection. A malar rash, as in lupus, may also occur.<sup>5, 12</sup>

Carditis and polyarthritis may mimic acute rheumatic fever. In Lyme disease, however, there is no evidence of preceding streptococcal infection or valvular cardiac involvement.

Central nervous system manifestations of Lyme disease may suggest brain tumor, Alzheimer's disease, multiple sclerosis, or primary psychiatric illness. The arthritis may be mistaken with the pauci-articular form of JRA, with Reiter's syndrome, and if monoarticular and involving the great toe, with gout. There may be symmetrical joint disease closely mimicking adult onset rheumatoid arthritis. In Lyme disease, rheumatoid factor studies



have been negative.<sup>5, 6, 12</sup>

Whether or not infectious mononucleosis is present is important, as serum from these patients may be associated with false-positive reactions with *B. burgdorferi*.<sup>13</sup> Further complicating the diagnosis can be the presence of splenomegaly and lymphadenopathy.

### Treatment

The decision for therapy in a given patient ultimately requires the determination that disease is present. As has been indicated earlier, the presence of antibodies to *B. burgdorferi* alone is not adequate to make a judgment to initiate treatment. If the diagnosis of Lyme disease is made, then the question of which stage of the disease is present influences the choice of antibiotics. In the early stages, most observers agree that tetracycline, if not contraindicated by pregnancy or being a child, is the appropriate treatment for periods ranging from 14 to 28 days. (Doxycycline, 100 mg. BID; tetracycline, 250/500 mg. QID

in the adult). In children, amoxicillin or erythromycin may be used. This also has been recommended for adults.<sup>14</sup>

**I**n the late and intermediate stages of Lyme disease, there has been uncertainty as to the results of therapy. (This also is true to a lesser extent concerning the early stages.) As to choice of antibiotic, high-dose intravenous penicillin (20 million units/day x 21 days) has been used. However, the use of ceftriaxone is currently the most accepted form of treatment.<sup>15</sup> (Two grams IV daily for 14 to 21 days). The long-term results of therapy remain to be determined.

### Acknowledgments

To Mrs. Virginia Stringfield, we extend our sincere appreciation for preparing this manuscript. To Dr. James H. Oliver, Jr., our thanks for review and help with this work.

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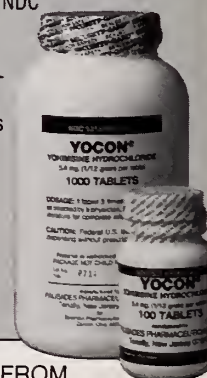
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# PRO Review Part III: Quality Review, Intervention, and Sanction

Susan Moore, R.N., M.P.H., C. Patrick Ryan, Ralph A. Murphy, M.D.

*(Parts I and II of this article appeared in the August and September issues of the Journal, respectively)*

**T**HE PURPOSE of this article is to increase your awareness of the multifaceted nature of the quality review, intervention, and sanction process. It is also intended to provide clarification and to assure the medical community that determinations are not made swiftly or carelessly. Physicians who practice in the same specialty and often in a similar setting as those being reviewed are involved in every aspect of the review process to provide true peer review.

To comply with the requirements for quality review in the current contract (Third Scope of Work), the Georgia Medical Care Foundation (GMCf) has developed a revised Quality Review and Intervention Plan (the "Plan"). This Plan was developed by GMCf staff and the quality subcommittee of the GMCf Board

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## **The quality review/ intervention effort of GMCf is essentially a three part process: Quality Review, Quality Intervention, and Sanction.**

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of Directors, with input from the Medical Association of Georgia, the Georgia Osteopathic Medical Association, and the Georgia Hospital Association. It is the cornerstone of GMCf's review activities.

The Plan is intended to identify, monitor, and correct confirmed quality of care issues associated with specific providers and/or prac-

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tioners. GMCf Review Coordinators, who are typically RNs, perform all initial reviews. Confirmation of all quality problems are made by GMCf Physician Consultants.

To better understand the PRO's responsibilities, an overview of the steps of the review/intervention sequence is in order. The quality review/intervention effort is essentially a three-part process, including: Quality Review, Quality Intervention, and Sanction.

### **Quality Review**

GMCf Review Coordinators refer quality screen failures which represent potential quality problems to appropriate physician consultants. These individuals use their clinical judgment to determine whether the health care services delivered were appropriate and meet acceptable standards as defined by the medical community in the state. Physician consultants of the same medical specialty and practice setting are used to promote focused, fair, and comprehensive reviews.

Reviews by the first Physician Consultants identify potential deficiencies, determine the source of the deficiencies, and assign preliminary severity levels. Severity levels are mandated in accordance with Health Care Financing Administration (HCFA) definitions and are as follows:

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**Sanction recommendations to the Inspector General are reserved for those situations where the GMCF Executive Committee determines that a practitioner or provider poses imminent risk to the health of Medicare beneficiaries and/or demonstrates an unwillingness or inability to comply with statutory obligations.**

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Level I — Medical mismanagement *without the potential* for significant adverse effects on the patient.

Level II — Medical mismanagement *with the potential* for significant adverse effects on the patient.

Level III — Medical mismanagement *with significant* adverse effect on the patient.

**T**he responsible physician and/or provider is notified by way of a Preliminary Request for Additional Information of the potential quality problems and offered an opportunity to respond in writing. Only written responses received within the designated time frame will be used prior to the initiation of a Final Quality Determination Notification. Therefore, physicians are encouraged to respond, as it will prompt

a second physician review of the case. In the absence of additional information, the initial determination will be upheld without further review.

On receipt of the written additional information, the case is reviewed by a second Physician Consultant of the same specialty and practice setting. GMCF will make a final determination based on all information available at the point of final review by the second Physician Consultant.

GMCF will issue a Final Quality Determination Notification to the responsible party involved, indicating confirmation of a quality problem or appropriate care. If a quality problem is confirmed, this notice will include (1) a description of the problem, (2) a suggested alternative course of action, and (3) the severity level. Since quality determinations are not denials of reimbursement (at this time), there is no reconsideration or appeal process for reversal of the severity level once it is assigned.

By the completion of the Quality Review step, a case has been reviewed independently by two physicians of the same specialty and practice setting, and the physician/provider has had an opportunity to submit clarification/justification.

#### **Quality Intervention**

Final Quality Determination Notifications are issued on confirmed quality problems and are evaluated for intervention during profiling, an activity which occurs quarterly. The profiling exercise permits meaningful focus on practitioners and providers. Beginning with the Second Scope of Work in 1986, of the 5.7 million cases subjected to quality screens, 390,000 (6.8%) were determined to have confirmed quality problems by physician reviewers. As a part of the profiling exercise, HCFA mandated numeric values are to be assigned to each quality problem based upon its severity level: Level I = 1; Level II = 5; Level III = 25. For example, during the July through September quarter, if a doctor had three confirmed Level III quality problems and four confirmed Level I quality problems, his

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**The practicing physician community should recognize the obvious need for active participation in the PRO review process to provide proper balance and perspective to quality of care reviews.**

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or her Level II score would be 15 ( $3 \times 5$ ) and Level I score would be 4 ( $4 \times 1$ ), for a total weighted severity score of 19 ( $15 + 4$ ).

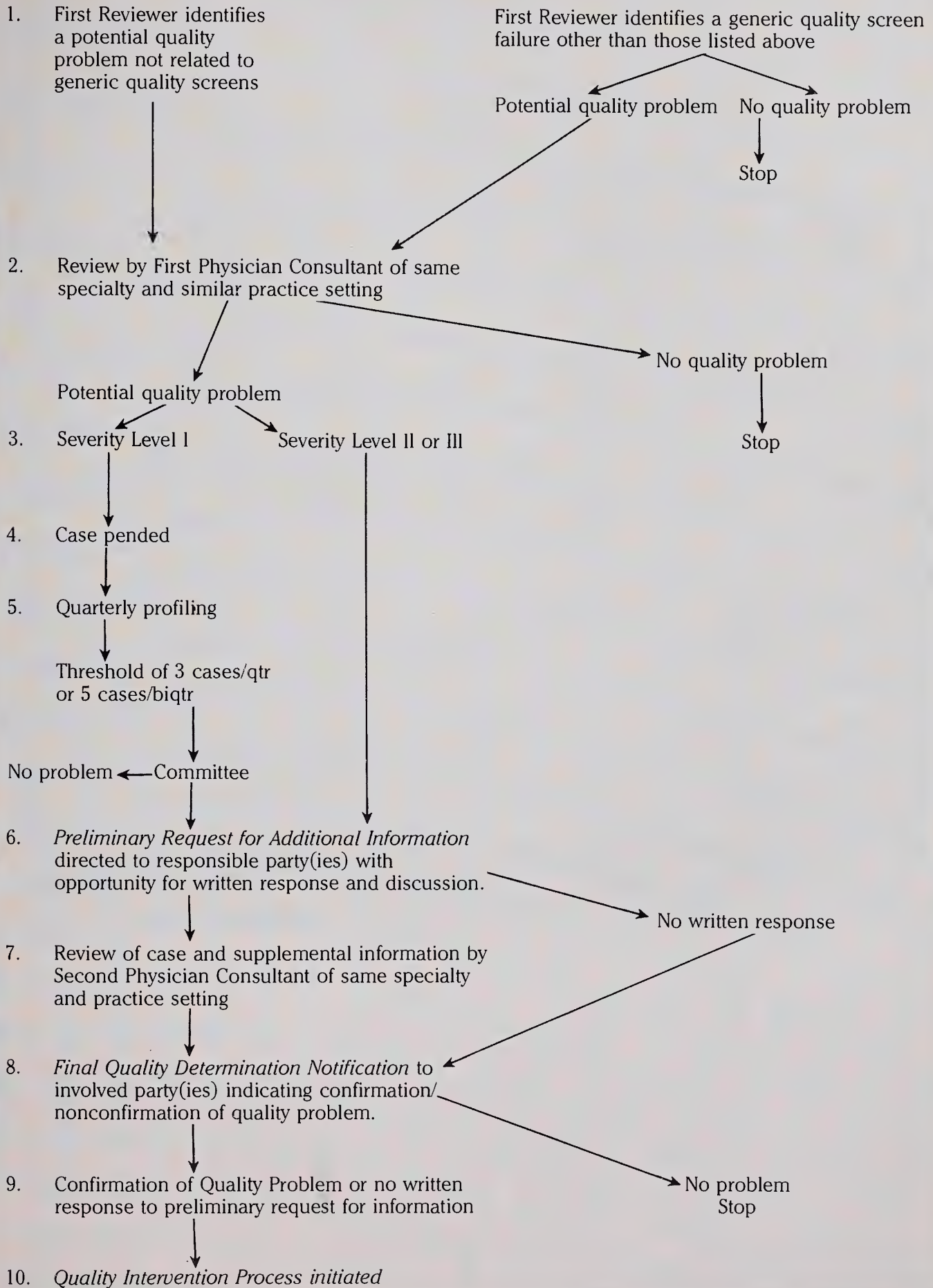
**I**t is important to understand that the weighted severity score is merely an internal PRO mechanism to identify physicians and providers whose cases require further review by committee. Decisions and actions are not based upon the weighted severity score. The total score serves as a guide for considering appropriate forms of intervention. Actual interventions are decided on a case-by-case basis. Furthermore, GMCF's weighted score totals are based only on reviews of the specified quarter. That is, new scores are calculated quarterly.

Within 45 days of the end of each quarter, Intervention Committees will review the identified quality issues and determine the appropriate type of interventions to be implemented. Each quarter as many as 10 Intervention Committees will be convened to review the identified confirmed quality problems. These 3-5 practicing physician member intervention committees include at least one member of the same specialty area as the physician being reviewed, and all are new to the case. The Interventions Committee can make one of the following three decisions:

- (1) The case requires no further action
- (2) The case warrants the implementation of an education or other corrective action intervention

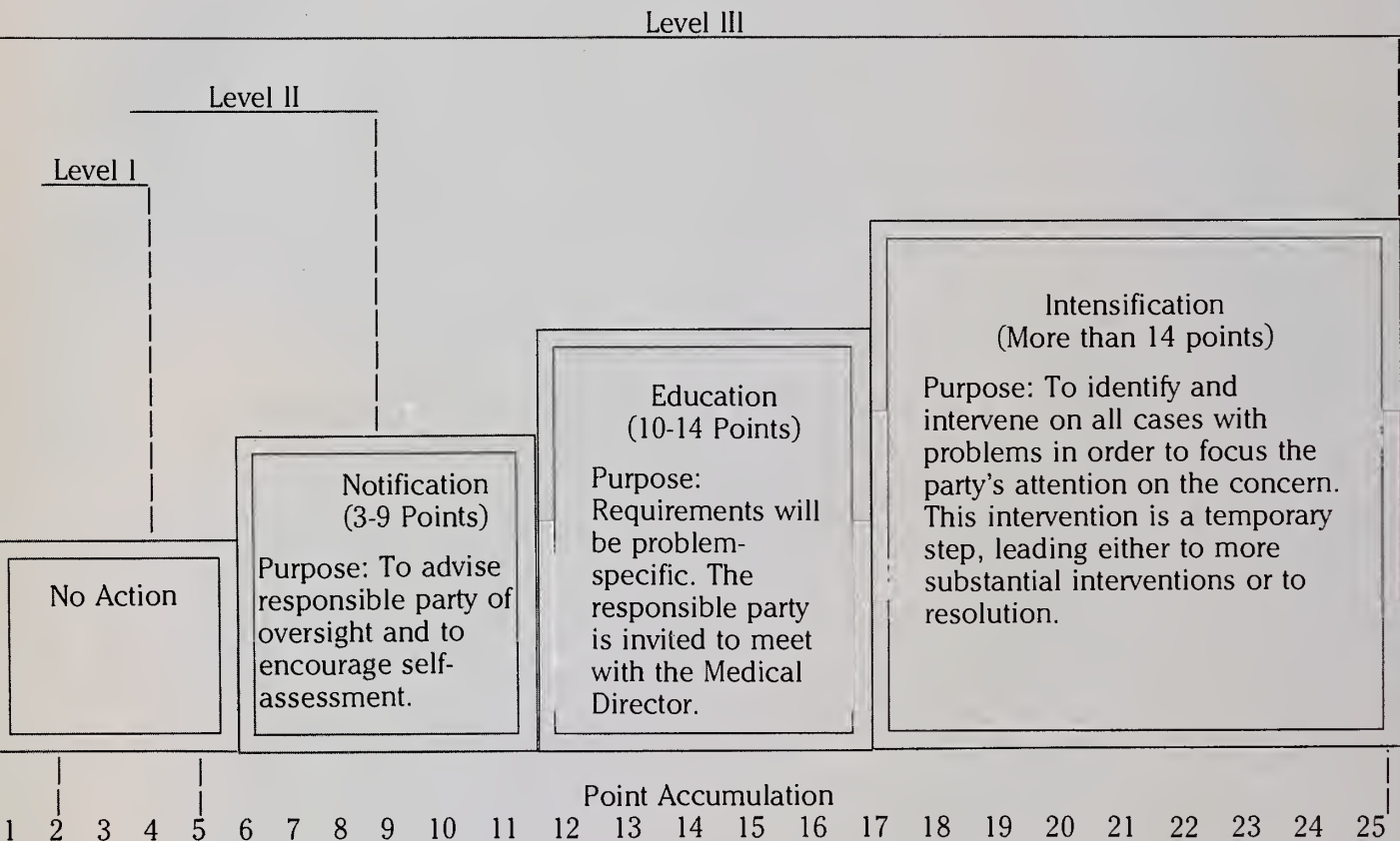


## QUALITY REVIEW PROCESS



## Quality Intervention Process/Point Accumulation

Level I = 1 Point  
Level II = 5 Points  
Level III = 25 Points



The following actions are considered if 25 points or more are reached in a quarter or if the Interventions Committee has other significant concerns:

- Coordination with Licensing Bodies
- Initiation of sanction process

(3) The case requires the initiation of the sanction process

If the Interventions Committee recommends intervention, one or more of a hierarchy of HCFA-mandated corrective interventions can be initiated. Interventions include notification, education, intensified review of discharges, or referral to the appropriate hospital committee for corrective action. GMCF expects that most corrective interventions will be educational in

nature. Examples of education interventions include suggested or required literature specific to the deficiency, suggested or required participation in continuing medical education courses and/or self-education courses.

By the completion of the Quality Intervention step, a given case has been reviewed by up to five physicians. This, when added to the two reviews which have already occurred, totals seven physician reviews.

### Sanctions

As discussed above, major emphasis will be placed on the correction of identified problems and the modification of unacceptable practice patterns through educational and/or other interventions directed specifically at the involved person(s). Where corrective action is not successful, GMCF is required to identify and evaluate all potential violations by practitioners and providers to meet their obligations under Medicare in accordance with



the policies and procedures outlined in the GMCF Sanction Plan. Sanction recommendations to the Office of the Inspector General (OIG) will be reserved for those situations where the GMCF Executive Committee determines that a practitioner or provider poses imminent risk to the health of Medicare beneficiaries and/or demonstrates an unwillingness or inability to comply with statutory obligations.

Historically, the data indicate that while state PROs have reviewed a large number of discharges, very few sanction recommendations have been made, and even fewer sanctions have been imposed by the OIG.

According to statistics compiled by the HCFA, since the advent of the Prospective Payment System in 1983, there have been nearly 45,000,000 hospital discharges involving Medicare beneficiaries. PROs have reviewed approximately 7,000,000 of these discharges. As of February 28, 1989, PROs have recommended a sanction in less than 200 cases. The OIG has imposed a sanction in approximately 100 of these cases.<sup>1</sup>

**S**ection 1156 of the Social Security Act imposes certain statutory obligations upon those who provide services under Medicare. These obligations are to assure that the services meet the following criteria:

1. Provided economically and only when, and to the extent they are medically necessary
2. Of a quality that meets professionally recognized standards of health care
3. Supported by the appropriate evidence of medical necessity and quality of the services in a form and fashion as may be required

Should the Intervention Committee decide to initiate the sanction process rather than proceed with the interventions described above, an Initial Sanction Notice is directed to the involved party. If the Committee recommends issuing the first sanction notice, it must also determine and confirm that the practitioner/provider either:

1. Failed in a substantial number of cases to substantially comply with any obligation imposed under Section 1156 of the Act; or
2. Grossly and flagrantly violated any such obligation in one or more instances.

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**By the completion of the Quality Review step, a case has been reviewed independently by two physicians of the same specialty and practice setting, and the physician/provider has an opportunity to submit clarification/justification.**

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The distinction is an important one, because gross and flagrant violations may pose an imminent danger to patients and because of the differences in notice requirements between these types of violations. One of two sanctions may be imposed:

1. A monetary penalty for no more than the "actual or estimated cost of the medically improper or unnecessary service so provided," or
2. Exclusion from the Medicare program for a specified period of time.

As the system presently operates, GMCF must provide the practitioner or provider with "reasonable notice and opportunity for discussion" before making its recommendation to the OIG. The provider is entitled to *two notices* and *two opportunities* to submit additional information and/or meet with the GMCF Medical Review Committee to discuss an allegation of "substantial violation in a substantial number of cases." The Medical Review Committee is com-

prised of three to five physicians, at least two of whom are in the same specialty. With an allegation of "gross and flagrant violation(s)," the provider is entitled to *one notice* and *one opportunity* to submit additional information and/or meet with the Medical Review Committee.

Based on review of the additional information, the Medical Review Committee determines whether or not it will recommend sanctioning. If a sanction recommendation is made, it is reviewed by the GMCF Executive Committee prior to the issuing of a Final Sanction Notice recommendation to the responsible party. A copy is also directed to the Inspector General for final disposition.

If GMCF recommends the imposition of a sanction, the physician or provider must be given 30 days notice and an additional opportunity to submit written comments to the OIG.

**I**t is important to emphasize that sanctions are the ultimate penalties which may only be imposed after an individual or organization has been shown to be unwilling or unable to correct the problems identified by the PRO's review process and quality intervention plan or poses an immediate threat to patient well-being. The Inspector General decides whether the sanction should be imposed only after considering the evidence presented and verifying that the PRO has followed all applicable statutes and regulations. The OIG may accept, reject, or modify the sanction recommendations forwarded by the PRO.

If the OIG accepts the recommendation, this finding will be published in the community. The physician or provider may appeal the sanction to an Administrative Law Judge who will conduct a hearing to review the facts of the case. If dissatisfied with that appeal, the sanctioned party may then appeal to the Secretary's Appeals Council and may thereafter seek judicial review in court.

It is important to note that the Omnibus Budget Reconciliation Act of 1987 gives rural practitioners additional protection. That is, they may

request a hearing before an Administrative Law Judge before a decision to exclude from Medicare is made.

### Summary

The above material represents a detailed discussion of the GMCF quality review plan, the quality intervention plan, and the sanction plan. It should be clear that every effort is being made by GMCF-PRO to provide fair, realistic, and commonsense quality of care reviews to the physician and hospital community of Georgia. It should also be evident that GMCF interventions will focus on education. Practicing physicians of the appropriate specialty are involved at every level of the review, intervention, and sanc-

tion process. Due process is afforded to physicians and hospitals in each plan as described above. The practicing physician commu-

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**Interventions include notification, education, intensified review of discharge, or referral to the appropriate hospital committee for corrective action.**

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nity should recognize the obvious need for active participation in the PRO review process to provide

proper balance and perspective to quality of care reviews.

The GMCF 29-member board (23 physicians) is committed to the concept of maintaining practicing physician involvement and participation in the HCFA-PRO program as mandated by Congressional legislation. It is necessary also for GMCF to continue with close communication to MAG and all specialty societies in order to ensure the recruitment of specialty physician consultants for a quality chart review program, review of screening criteria, and review committee participation.

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# The Physicians For Rural Areas Assistance Act

Joe B. Lawley

**A**lthough there is a projected oversupply of physicians in the United States by the year 2000, there appears to be a basic physician maldistribution problem in Georgia. In 1987, Georgia ranked first in teenage pregnancy and third in infant mortality.<sup>1</sup> Seventy-seven counties in Georgia are currently designated in whole or in part as health manpower shortage areas by the Department of Health and Human Services.<sup>2</sup> According to the 1986 Georgia Physician Report by the Joint Board of Family Practice, approximately 3,676 physicians will retire in Georgia between 1980 and the year 2000.<sup>3</sup> The majority of of these countries with physician shortage areas and retiring physicians are located in rural Georgia.

This physician maldistribution extends through the South as well as the entire nation. Recommendations by the Carnegie Commission,<sup>4</sup> American Rural Health Association,<sup>5</sup> Southern Regional Education Board,<sup>6</sup> and the Council on Graduate Medical Education<sup>7</sup> stress the need to develop methods to assure the distribution of physi-

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**These programs to attract practicing physicians into rural areas form an inexpensive, efficient, interagency system of activities that may have a significant impact on resolving physician maldistribution in the state.**

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cians to areas of need. These groups also recommend giving this critical problem the kind of attention that has been given in the past two decades to increasing health manpower numbers. It seems evident that the problem of maldistribution of physicians will not resolve itself without continued attention. An effective combination to redress physician maldistribution, particularly in rural Georgia, may include a clear

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emphasis on health care agency interaction, incentives for young primary care physicians to practice in areas of need, access to health care for all citizens in the underserved areas, and activities that bring physicians and community officials together to discuss and make decisions about practice opportunities.

In Georgia, 18 public and private agencies are working together to address this problem. The agencies are as follows:

Medical Association of Georgia  
Medical College of Georgia  
Georgia Bankers Association  
Georgia Hospital Association  
Joint Board of Family Practice  
State Medical Education Board  
Georgia Rural Health Association  
Mercer University School of Medicine  
Georgia Academy of Family Physicians  
Georgia Association for Primary Health Care  
Georgia Chapter, American Academy of Pediatrics  
Georgia Chapter, American College of Physicians

Georgia Chapter, American College of Surgeons  
 Georgia Osteopathic Medical Association  
 Georgia Department of Human Resources  
 Georgia Department of Community Affairs  
 The University of Georgia Cooperative Extension Service  
 Georgia Hospital Association  
 Council on Small and Rural Hospitals

### The Loan Repayment Program

Discussions between a number of these agency representatives and board members during the past 12 months, has resulted in their participation in drafting and supporting House Bill 567, "The Physicians For Rural Areas Assistance Act," which was passed by the 1989 Session of the Georgia General Assembly and signed by Governor Joe Frank Harris on April 13, 1989. This bill provides that the State Medical Education Board (The "Board") will administer, with the advice and assistance of other public and private associations and organizations, a Loan Repayment Program that will give priority to those applicants who are physicians specializing in and actively practicing obstetrics. After giving such priority, the Board may also consider the applications of physicians specializing in obstetrics/gynecology, family practice, general practice, general internal medicine, general pediatrics, general surgery, psychiatry, or other medical specialties approved by the Board.

Under this program, the Board may grant physicians service-cancellable loans of up to \$20,000 per year toward repayment of their medical education debt in return for the physician's agreement to practice for at least 2 years in a board-approved rural area. A physician may receive a renewable grant under this program for up to 4 years. The general criteria to determine rural areas is as follows:

1. The ratio of physician to population in the area:

2. Indications of the health status of the population in the area;
3. The poverty level and dependent age groups of the population in the area;
4. Indications of community support for more physicians in the area; and
5. Indications that access to the physician's services is available to every person in the underserved area regardless of ability to pay.

The State Medical Education Board will work in cooperation with several agencies to conduct an annual assessment of the need and demand for primary health care manpower in the counties and other areas of the state. The type of data collected and treatment of the data to determine target counties can be obtained by contacting the office of the State Medical Education Board. The counties selected for this program beginning July 1, 1989 to June 30, 1990, are as follows:

Atkinson	Mitchell
Baker	Quitman
Brooks	Randolph
Calhoun	Seminole
Candler	Stewart
Clinch	Talbot
Dodge	Taliaferro
Hancock	Tattnall
Harris	Taylor
Jefferson	Terrell
Jenkins	Treutlen
Johnson	Turner
McIntosh	Warren
Macon	Webster
Marion	Wilcox
Miller	

Each county selected with the above criteria and approved by the Board must express interest in the program by completing an application. Indications of community support as requested in the application may include, but not be limited to, the following: a) indications that county leaders will support an incoming physician, b) assurances that the physician from this program will have access to a hospital and will be eligible for considera-

tion for hospital privileges, c) assurances that the physician will have time to be with family and to participate in professional continuing education. Applications should indicate what type of practice is available for the incoming physician; what referral and back-up services are to be provided; what the potential is for sound peer group relations, and what provision will be made for malpractice insurance. Relocation allowance, low interest loans, financial income guarantee for a period of time, office rent-free for a period of time, and access to an older, established physician for council, advice, and support will also be encouraged. Indications of how the spouse and children of the physician (if any) will be accommodated will be requested. Indications of how the county plans to retain the physician after the contract under this program has expired will be encouraged.

Each target area will be requested to identify methods already in place or may be developed to guarantee access to physician services and payment to the physician for indigent patient care. The application should indicate if the target area intends to provide financing and training of personnel who will enroll and assist patients with third party payor applications.

The counties or target areas selected will not be ranked in priority order for placement purposes. The counties will compete with each other for approximately ten physicians during 1989-90. This approach is intended to encourage the county or counties to involve their public and private health care leadership and county officials in designing their approach, coordinating their existing medical care, and preparing a package to attract a physician. The inclusion, participation, agreement and leadership of local physicians in the plan to recruit and retain a physician under this program is most important. Encouragement will be given to the target area to present an integrated system of health care to the prospective physician describing how hospital, local physicians, health care providers, primary care cen-



ters, and state and county officials in the target area will work together with the incoming physician. Each target area will be encouraged to present a plan concerning how access to the physician's services will be made available to every person in the target area regardless of ability to pay.

It is believed that the opportunity to recruit a critically needed physician will motivate county leaders and health care providers to coordinate a health care plan for inclusive services in target areas. The potential increase in health care services and the physician's economic impact on the local area may motivate the county leaders to activate their markets and to recruit and retain a physician from this program. It calls upon the target area to bring together its leadership and health care resources, while at the same time bringing the resources, information, communication, and professional expertise of 18 agencies to bear on any one situation at a given time.

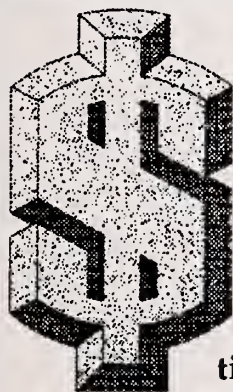
**It is believed that the opportunity to recruit a critically needed physician will motivate county leaders and health care providers to coordinate a health care plan for inclusive services in target areas.**

The above program for physicians completing their medical training is linked to: (1) the traditional "Country Doctor" scholarship awards made by the State Medical Education Board to medical students and (2) the annual Medical Fair which brings young physicians together with rural communities to talk about practice opportunities in Georgia. These programs form an inexpensive, ef-

ficient, interagency system of activities that may have a significant impact on resolving physician maldistribution in the state. The system of activities is made possible because of the cooperative interest, participation, and professional assistance of the agencies involved.

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# A Profile of the Medically Uninsured in Georgia

Michael Rafferty, M.D.

## Introduction

**W**HILE THERE ARE SEVERAL estimates of the number and demographic profile of persons uninsured for health care for the U.S. as a whole,<sup>1,2</sup> there are no such estimates for the population of Georgia. At the same time, the problem of how to pay for health services for the uninsured has so far been left to state and local governments and to the charitable efforts of hospitals, doctors, and private agencies. All concerned need reliable data to tailor an approach suitable to local needs. Both the Georgia Hospital Association<sup>3</sup> and the Association County Commissioners of Georgia<sup>4</sup> have recently looked at this problem from the perspective of Georgia hospitals and Georgia county governments. In order to

## Abstract

**T**he provision of health care to the growing number of persons uninsured against medical expenses affects Georgia doctors, hospitals, and state and local government at all levels. While much is known nationally about the uninsured, there are no good data about this group in Georgia. This study uses U.S. Census Bureau data to provide a demographic profile of Georgians who lack health insurance and to identify groups at particular risk for being uninsured. Approximately 950,000 (17.7%) of non-elderly Georgia residents are uninsured, compared to 37 million (17.6%) in the U.S. as a whole. As is true generally in the U.S., those in Georgia who are poor, young, non-white, and in families with a female head are at greatest risk. Of particular note are the poor in Georgia with incomes from 50% to 100% of the federal poverty level (55.2% uninsured). This population deserves the special attention of all involved in finding a solution to this problem.

further define the problem, this study uses the 1987 Current Population Survey of the U.S. Census Bureau to make some estimates of the number and demographic characteristics of the uninsured population in Georgia and to compare these estimates to those obtained for the United States as a whole. The number of non-elderly Georgia residents uninsured for health care ex-

penses is approximately 950,000, or 17.7% of the population under 65 years old; by comparison 37 million (17.6%) of the non-elderly in the U.S. as a whole are uninsured. In general, the profile of the uninsured is the same in Georgia as in the United States, with those who are poor, young, non-white, and in families with a female head at greatest risk. However the poor in Georgia with in-

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Data were provided by the Data Services of the University of Georgia and the U.S. Bureau of the Census. The analyses and conclusions presented here are those of the author and do not necessarily reflect those of the Division of Public Health, the Department of Human Resources, or Emory University.

comes from 50% to 100% of the federal poverty level are at particular risk (55.2% uninsured) compared to their counterparts in the general population (36.1% uninsured in the U.S. as a whole). This population deserves the special attention of those involved in crafting a solution to this problem.

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**In this state, few public assistance programs are available to this segment of the poverty population.**

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**Methods**

The Current Population Survey (CPS) is conducted monthly by the U.S. Census Bureau and is the source of official government unemployment figures.<sup>5</sup> In March of each year, questions about income and income-related characteristics, such as coverage by a health insurance plan, are added to the basic questionnaire. The universe is the civilian non-institutionalized population of the United States, and each month data about 163,000 persons in 70,000 households throughout the U.S. are collected. Responses are weighted to allow estimation of parameters for the population of interest as a whole. The method of sampling employed in the survey was redesigned in 1986 to make each state its own sampling frame, making possible estimates of parameters state by state.<sup>6</sup> The tabulations presented here are taken from the March 1987 CPS and represent responses to questions about coverage for health insurance during 1986. In each household surveyed, a single respondent is asked to provide information about each individual in the household and about the family structure of the family or families living in that household. In this report, only the non-elderly are considered, since coverage by Medicare is almost universal among those over 65 years of age.

Standard errors are provided for estimated percentages and were calculated for the U.S. in the following manner<sup>7</sup>:

$$S = \sqrt{(B/T) \times (p) \times (100-p)}$$

where:

- S = Standard Error
- B = 2077 for white or total population  
= 2374 for black and other races
- T = Size of the subclass of persons (e.g., persons under 18 years old)
- p = Percentage of persons in the subclass with the characteristic of interest (e.g., insured or not insured)

Standard errors for Georgia are calculated in the same way and are inflated by a factor of 1.25 according to the method provided by the Census Bureau.<sup>8</sup> To test the difference between the percentage uninsured in Georgia and in the U.S., the standard error of the difference between the two percentages was calculated by the following formula:

$$dS = \sqrt{S(g)^2 + S(u)^2}$$

- dS = Standard error of the difference between the percentage uninsured in Georgia and the percentage uninsured in the U.S.
- S(g) = Standard error of the parameter in Georgia
- S(u) = Standard error of the parameter in the U.S.

This provides a conservative estimate (overestimate) of the standard error of characteristics that have a high positive correlation;<sup>7</sup> all comparisons of characteristics (such as the percentage of persons under 18 without insurance) made between Georgia and the U.S. meet this test. The null hypothesis of no difference in percentages for Georgia and the U.S. for a given characteristic was then tested making a further assumption that for the large sample sizes in this study the distribution of the test statistic *z* may be approximated by the normal distribution.<sup>9</sup> *Z* was calculated as follows:

$$z = \frac{P(g) - P(u)}{dS}$$

where:

- P(g) = Percentage uninsured in Georgia
- P(u) = Percentage uninsured in the U.S.

Estimated numbers are given in the nearest unit; standard errors of the estimated numbers of uninsured are not shown in this report but are available from the author upon request.

**Results**

There were 954,366 non-elderly persons uninsured for health care in Georgia in 1986, or 17.7% of the population in this age group. In the entire U.S., 37,052,994 (17.6%) non-elderly lacked health insurance in 1986. No differences between the percentage uninsured in Georgia vs. the U.S. were identified on any characteristic, although the percentage of children uninsured in Georgia approaches statistical significance (Table 1). Within each population, however, there are distinct differences between the percentage lacking health insurance when one compares those in Georgia under 18 (22.7%) with those older than 18 (15.5%), white with non-white (14.5% vs. 23.9%), those who live in the central portions of cities with those in all other areas (22.7% vs. 17.0%), or those who live in non-metropolitan vs. metropolitan areas (20.0% vs. 16.5%). These differences are significant at the *p*<.01 level (age, race), or approach significance (*p*<.10 – residence).

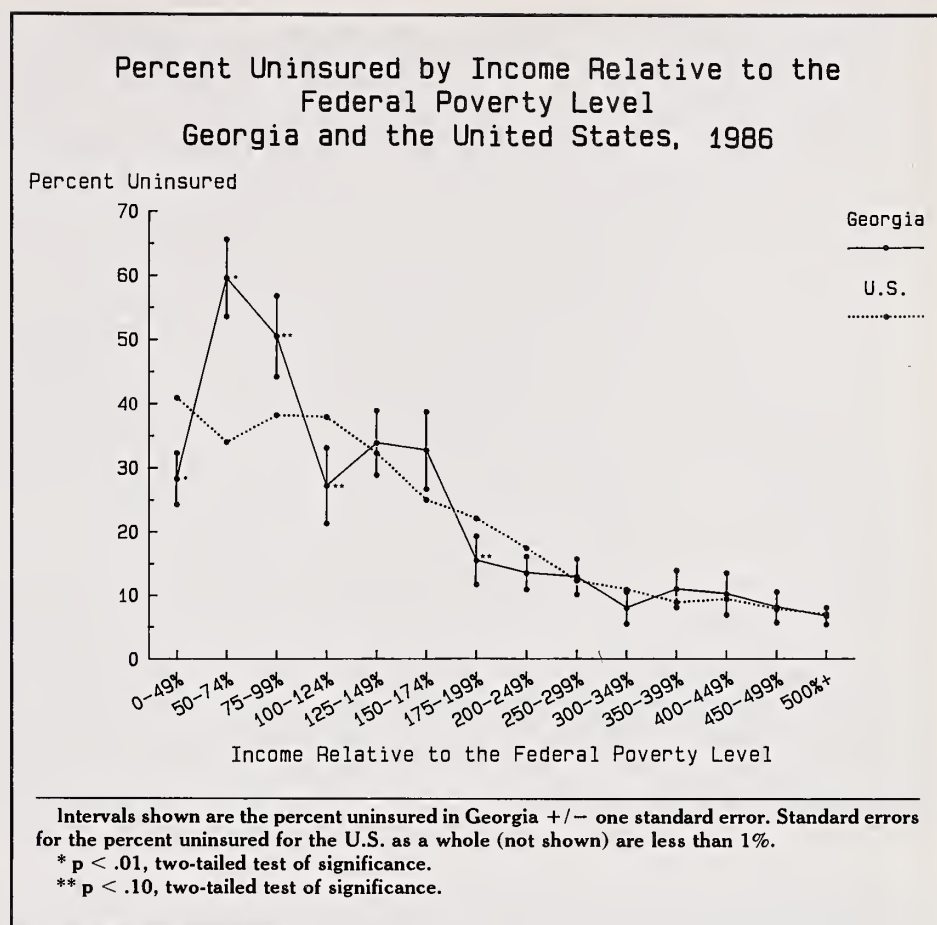
Since health insurance is often extended to members of a family through employment or welfare reciprocity by one of its members, the uninsured population was analyzed according to selected characteristics of the family and family head. In the following discussion, the family head is the member of the family with the greatest income, and a family in which at least one member is receiving public assistance is counted as receiving public assistance. The



effects of family characteristics on health insurance coverage differs little in Georgia than in the U.S. as a whole (Table 2). In Georgia perhaps a lower percentage of those in families whose head is a college graduate are uninsured (6.9% vs. 9.4% in the U.S.,  $p < .10$ ), while more of those in Georgia families in which no family member is working lack health insurance compared to the U.S. (33.9% vs. 26.7%,  $p < .05$ ). But, as with individuals, uninsured families in Georgia are like uninsured families generally in the U.S. Within each population, however, the characteristics listed have a great effect on coverage. In Georgia, those in female-headed families are almost twice as likely to be uninsured than those in male-headed families (24.5% vs. 14.6%), those in single-parent families (27.6% uninsured) and those whose family head is not a high school graduate (32.0% uninsured) are more than twice as likely to be uninsured than their counterparts in two-parent families (12.5%) and in families whose head finished high school (13.6%).

**I**n Georgia, those in unemployed families are more than twice as likely to be uninsured than those in families with at least one member working (33.9% vs. 15.3%). However, 75.6% of Georgia's uninsured come from working families (721,572 of 954,366), with only 24.4% (232,794) living in families with no working members. The problem is worse on farms, where 43.3% of those in families whose head works in agriculture lack insurance for health care.

The persons at greatest risk for being uninsured are those in families whose income falls below the federal poverty level. In Georgia, 351,951 of the 842,036 persons with family incomes below the poverty limit are uninsured (41.8% vs. 13.2% for the non-poor). Within this population, the poorest (incomes less than 50% of the poverty standard) are slightly better off than their counterparts in the general population (28.3% vs. 40.9% uninsured) (Figure 1). However, the poor in Georgia with incomes from 50 to 100% of the poverty limit (55.2%



uninsured) fare worse in terms of health insurance than either the U.S. population in this category or those in Georgia who are poorer. While the relationship between poverty and health insurance is approximately the same in Georgia as in the U.S. generally, the poor with incomes from 50 to 100% of the poverty standard are clearly worse off (Figure 1).

There are 423,077 persons in this income bracket (Table 3). Of these, 233,550 have no health insurance (55.2%). In the U.S. in general, 36.1% of those in this income group are uninsured (data not shown). Most of those in this income group in Georgia are from working families (283,622, or 67.0%), and of these 152,876, or 53.9%, lack health insurance. By contrast, 80,674 of 139,455 (57.9%) who are in families with no working member lack coverage. Medicaid covers 100,293 of these poor (23.7% vs. 38.1% in the U.S. in general), and of the remaining 322,784, 233,550 (72.4%) are uncovered by any form of health insurance. In contrast to the differences in rates of coverage seen be-

tween groups within the total population in Georgia (Tables 1 and 2), there are no differences in rates among these poor by age, race, sex, or marital status of the family head, or by employment status of the family. At this income level, where few public assistance benefits are available, the only predictor of health insurance coverage is qualification for public assistance. In this population, simply being poor is the main determinant of whether one has health insurance.

The working poor hold jobs in industries that are less likely to provide health insurance (Table 4). In Georgia, where the statewide average for all workers and their families is 15.3% uninsured, the "best" jobs are in financial services (9.5% uninsured), manufacturing (10.1%), and professional services (11.7%). The "worst" jobs are in wholesale or retail trade (20.0% uninsured), construction (22.6%), personal services (25.0%), and entertainment and recreational services (27.8%). In Georgia as a whole, the "best" industries account for 45% of all those in working families, but



TABLE 1 — Health Insurance Among the Non-Elderly Population by Selected Individual Characteristics  
Georgia and the United States, 1986

	Georgia				United States				p
	No Health Insurance	Total	Percent Uninsured	(SE)	No Health Insurance	Total	Percent Uninsured	(SE)	
All	954,366	5,406,474	17.7%	(0.9)	37,052,994	210,813,686	17.6%	(0.1)	NS
Age									
Under 18	360,920	1,589,292	22.7%	(1.9)*	12,235,982	63,182,578	19.4%	(0.2)	<.10
18-64	593,446	3,817,182	15.5%	(1.1)	24,817,012	147,631,108	16.8%	(0.1)	NS
Sex									
Male	443,253	2,577,372	17.2%	(1.3)	19,046,582	104,455,515	18.2%	(0.2)	NS
Female	511,113	2,829,102	18.1%	(1.3)	18,006,412	106,358,171	16.9%	(0.2)	NS
Race									
White	518,442	3,582,272	14.5%	(1.1)*	28,844,166	177,280,037	16.3%	(0.1)	NS
Non-White	435,924	1,824,202	23.9%	(1.9)	8,208,828	33,533,649	24.5%	(0.3)	NS
Residence									
Central City	139,927	616,235	22.7%	(3.0)†	11,137,186	53,249,019	20.9%	(0.3)	NS
Other	814,439	4,790,239	17.0%	(1.0)	25,915,808	157,546,667	16.4%	(0.1)	NS
Non-MSA	355,446	1,781,239	20.0%	(1.7)†	10,202,027	52,841,676	19.3%	(0.2)	NS
MSA	598,920	3,625,235	16.5%	(1.1)	26,850,967	157,972,010	17.0%	(0.1)	NS

MSA is Metropolitan Statistical Area.

SE is the standard error of the reported percentages.

p refers to a two-tailed test of significance for the difference between percentages for Georgia and the United States.

\* p < .01 for the difference between percentages within categories in Georgia, e.g. between under 18 and 18-64 years old.

† p < .10 for the difference between percentages within categories in Georgia.

TABLE 2 — Health Insurance Among the Non-Elderly Population by Selected Family Characteristics  
Georgia and the United States, 1986

	Georgia				United States				p
	No Health Insurance	Total	Percent Uninsured	(SE)	No Health Insurance	Total	Percent Uninsured	(SE)	
Sex of Family Head									
Male	542,205	3,724,506	14.6%	(1.0)*	23,203,312	150,449,386	15.4%	(0.1)	NS
Female	412,161	1,681,968	24.5%	(1.9)	13,849,682	60,364,302	22.9%	(0.2)	NS
Family Type									
Married Couple	449,257	3,597,453	12.5%	(1.0)*	20,053,122	151,069,373	13.3%	(0.1)	NS
Single Parent	505,107	1,809,020	27.9%	(1.9)	16,999,872	59,744,314	28.5%	(0.3)	NS
Education of Family Head									
Not High School Grad	378,970	1,185,043	32.0%	(2.4)*	12,596,487	39,390,059	32.0%	(0.3)	NS
High School Grad	575,395	4,221,430	13.6%	(1.0)	24,456,507	171,423,629	14.3%	(0.1)	NS
Not College Grad	870,812	4,199,033	20.7%	(1.1)*	32,282,538	159,910,124	20.2%	(0.1)	NS
College Grad	83,554	1,207,442	6.9%	(1.3)	4,770,456	50,903,562	9.4%	(0.2)	<.10
Family Income									
Below Poverty Level	351,951	842,036	41.8%	(3.1)*	11,700,917	30,546,006	38.3%	(0.4)	NS
Above Poverty Level	602,415	4,564,438	13.2%	(0.9)	25,352,077	180,267,681	14.1%	(0.1)	NS
Public Assistance Received by Family									
None	926,227	5,102,160	18.2%	(1.0)*	36,296,339	197,369,473	18.4%	(0.1)	NS
AFDC or Other Assistance	28,139	304,313	9.2%	(3.0)	756,655	13,444,214	5.6%	(0.3)	NS
Family Members Working									
None	232,794	686,973	33.9%	(3.3)*	7,379,761	27,660,205	26.7%	(0.4)	<.05
At Least One	721,572	4,719,501	15.3%	(0.9)	29,673,233	183,153,481	16.2%	(0.1)	NS
Family Head Works in Agriculture									
No	931,010	5,352,549	17.4%	(0.9)†	35,639,342	206,545,649	17.3%	(0.1)	NS
Yes	23,356	53,925	43.3%	(12.2)	1,413,652	4,268,037	33.1%	(1.0)	NS

Family Head is the member of the family with the greatest income.

A family in which at least one member is receiving public assistance is counted as receiving public assistance.

SE is the standard error of the reported percentages.

p refers to a two-tailed test of significance for the difference between percentages for Georgia and the United States.

\* p < .01 for the difference between percentages within categories in Georgia, e.g. between male and female family heads.

\*\* p < .05 for the difference between percentages within categories in Georgia.



only 33% of workers and their families among the working poor. The "worst" industries account for 36% of all working Georgians and their families but 54% of the working poor. This group fares worse even within the same industries — 55% in the "best" industries are uninsured, compared to 11% for all Georgians, and 54% in the "worst" industries are uninsured, compared to 21% for all Georgians. Except in construction, where the numbers are small, within any industry the working poor are always more likely to be uninsured than the population as a whole. Both the kinds of jobs (industries) available to the working poor and the jobs within those industries contribute to the lack of health insurance in this group.

### Discussion

The uninsured use fewer health services than the insured<sup>10</sup> and forego needed care because of non-coverage.<sup>2</sup> Many are chronically ill<sup>11</sup> and in need of on-going care, while others are denied admission to the hospital even when acutely ill.<sup>12</sup> When the uninsured cannot pay their medical bills, doctors, hospitals, or local governments who operate public facilities must absorb the cost. The federal government has failed to act to protect patients, health care institutions, and local governments from the difficulties that arise out of noncoverage, leaving the problem to state and local government and the private efforts of doctors and hospitals.

In order to better inform those working toward a local solution to this problem, this study examines the main predictors of health insurance coverage among the non-elderly population in Georgia, using as a point of reference those same predictors for the U.S. non-elderly population in general. There are few differences, with the notable exception that the poor in Georgia with incomes between 50 and 100% of poverty are at increased risk for non-coverage compared to the poor in this income bracket in the U.S. as a whole. In this state, few public assistance programs are available to this segment of the pov-

**TABLE 3 — Health Insurance Among the Non-Elderly Population in Georgia With Family Incomes From 50%-100% of Federal Poverty Level, 1986**

	<i>No Health Insurance</i>	<i>Total</i>	<i>Percent</i>	<i>(SE)</i>
<b>All</b>	<b>233,550</b>	<b>423,077</b>	<b>55.2</b>	<b>(4.4)</b>
<b>Age</b>				
Under 18	123,646	206,560	59.9	(6.1)
18-64	109,904	216,517	50.8	(6.1)
<b>Sex</b>				
Male	101,063	171,074	59.1	(6.8)
Female	132,487	252,003	52.6	(5.7)
<b>Race</b>				
White	62,771	128,771	48.6	(7.9)
Non-White	170,779	294,306	58.0	(5.6)
<b>Sex of Family Head</b>				
Male	108,275	193,280	56.0	(6.4)
Female	125,275	229,797	54.5	(5.9)
<b>Family Type</b>				
Married Couple	79,303	137,120	57.8	(7.6)
Single Parent	154,247	285,957	53.9	(5.3)
<b>Medicaid Coverage</b>				
No Medicaid Coverage	233,550	322,784	100.0	(0)*
Medicaid Coverage	0	100,293	0.0	(0)
<b>Public Assistance Received by Family</b>				
None	219,415	351,912	62.4	(4.7)*
AFDC or Other Assistance	14,135	71,165	9.9	(6.4)
<b>Family Members Working</b>				
None	80,674	139,455	57.9	(7.5)
At Least One	152,876	283,622	53.9	(5.3)

Family Head is the member of the family with the greatest income.

A family in which at least one member is receiving public assistance is counted as receiving public assistance.

\*p < .05 for the difference between percentages within categories, e.g. between Under 18 and 18-64 years old.

erty population. Within Georgia, the usual determinants of health insurance coverage — age, race, family structure, and employment status — do indeed predict coverage for the population in general. For the poor in Georgia between 50 and 100% of the poverty standard, however, these factors cannot be shown to predict insurance status. Certainly, the smaller numbers in this group increase the chance of missing a real difference (type 2 error), and for certain characteristics (e.g., age) the direction of the difference (e.g., younger more likely to be uninsured) is the same. But for other characteristics (e.g., sex of the family head), the direction is reversed, and within the limitations of the data it appears that the usual predictors are not valid. Put differently, poverty is the great "leveler" in this group, making all other determinants of health insurance coverage less relevant.

Of particular note is the relationship between work and health insurance. Among all Georgians, the great majority (76%) of the uninsured are from working families; membership in a non-working family doubles the risk of being uninsured. Similarly, among Georgians with incomes from 50 to 100% of poverty, the majority (67%) are from families with a working member; membership in an unemployed family, however, confers about the same risk of being uninsured.

The preferred solution is the creation of jobs in industries that provide health insurance to their employees. These jobs must also pay well enough to lift families out of poverty, since both the kind of industry and the income of its workers affect health insurance coverage (Table 4). Government in Georgia must encourage the right kind of economic development toward these ends; it must also en-



**TABLE 4 — Non-Elderly Persons in Employed Families by Occupation and by Health Insurance Coverage  
All Georgians and the Poor from 50% to 100% of Poverty Level, 1986**

Occupation	All Georgians					Poor from 50-100% Poverty				
	Employed	Percent of Total Employed	Uninsured Employed	Percent Uninsured (SE)		Employed	Percent of Total Employed	Uninsured Employed	Percent Uninsured (SE)	
All	4,719,501	100.0	721,572	15.3 (0.9)		283,622	100.0	152,876	53.9 (5.3)	
"Best" Industries										
Financial, Insurance, Real Estate	327,362	6.9	31,186	9.5 (2.9)		14,935	5.3	4,202	28.1 (21.0)	
Manufacturing	765,359	16.2	77,149	10.1 (2.0)		41,850	14.8	22,392	53.5 (13.9)	
Professional and Related Services	1,028,707	21.8	120,533	11.7 (1.8)		37,691	13.3	24,938	66.2 (13.9)	
"Best" Total	2,121,428	44.9	228,868	10.8 (1.2)		94,476	33.3	51,532	54.5 (9.2)	
"Worst" Industries										
Retail & Wholesale Trade	1,160,840	24.6	232,231	20.0 (2.1)		61,585	21.7	51,136	83.0 (8.6)	
Construction	339,229	7.2	76,697	22.6 (4.1)		44,913	15.8	2,808	6.3 (6.5)	
Personal Services Incl Private Households	117,515	2.5	29,365	25.0 (7.2)		27,794	9.8	10,572	38.0 (16.6)	
Entertainment and Recreational Services	66,806	1.4	18,582	27.8 (9.9)		18,582	6.6	18,582	100.0 (0.0)	
"Worst" Total	1,684,390	35.7	356,875	21.2 (1.8)		152,874	53.9	83,098	54.4 (7.3)	
Other	913,683	19.4	135,828	14.9 (2.1)		36,271	12.8	18,244	50.3 (15.0)	

Occupation is the longest job held in the previous year by the family member who worked as defined in Tables 2 and 3.

Other includes Agriculture, Forestry, and Fisheries; Mining; Transportation, Communications and Other Public Utilities; Public Administration; and some part-time workers and Armed Forces Personnel.

Categories are Census Bureau reclassifications of Standard Industry Codes, here further aggregated where numbers are small.

"Best" Industries are those in which the proportion of uninsured among workers and their families is less than 15.3% (statewide average for all workers and their families). "Worst" Industries are those in which the proportion of uninsured among workers and their families is greater than the statewide average. "Other" is excluded from this classification.

SE is the standard error of the percent uninsured.

courage job training to provide its citizens an opportunity to take such jobs, especially its poor citizens. Such an approach could provide health insurance to all but 11% ("best" rate) of the 722,000 in families now working but uninsured. For the remainder, and for those 233,000 in non-working families, maximization of Medicaid coverage by state participation in optional programs would cover some; the federal match to Georgia Medicaid of almost two to one makes this approach desirable where state money is available. Until such measures can be realized, however, the existing public system must be given continued support. Public hospitals and clinics, such as Atlanta's Grady Memorial Hospital, the various programs of support for indigent care in hospitals provided by some county govern-

ments, and programs that provide public health and personal health services through the Department of Human Resources deserve continued funding. Along with the voluntary efforts of hospitals, doctors, and charitable organizations, this public system must take care of the nearly 1,000,000 Georgians without insurance to pay for health care.

### Acknowledgements

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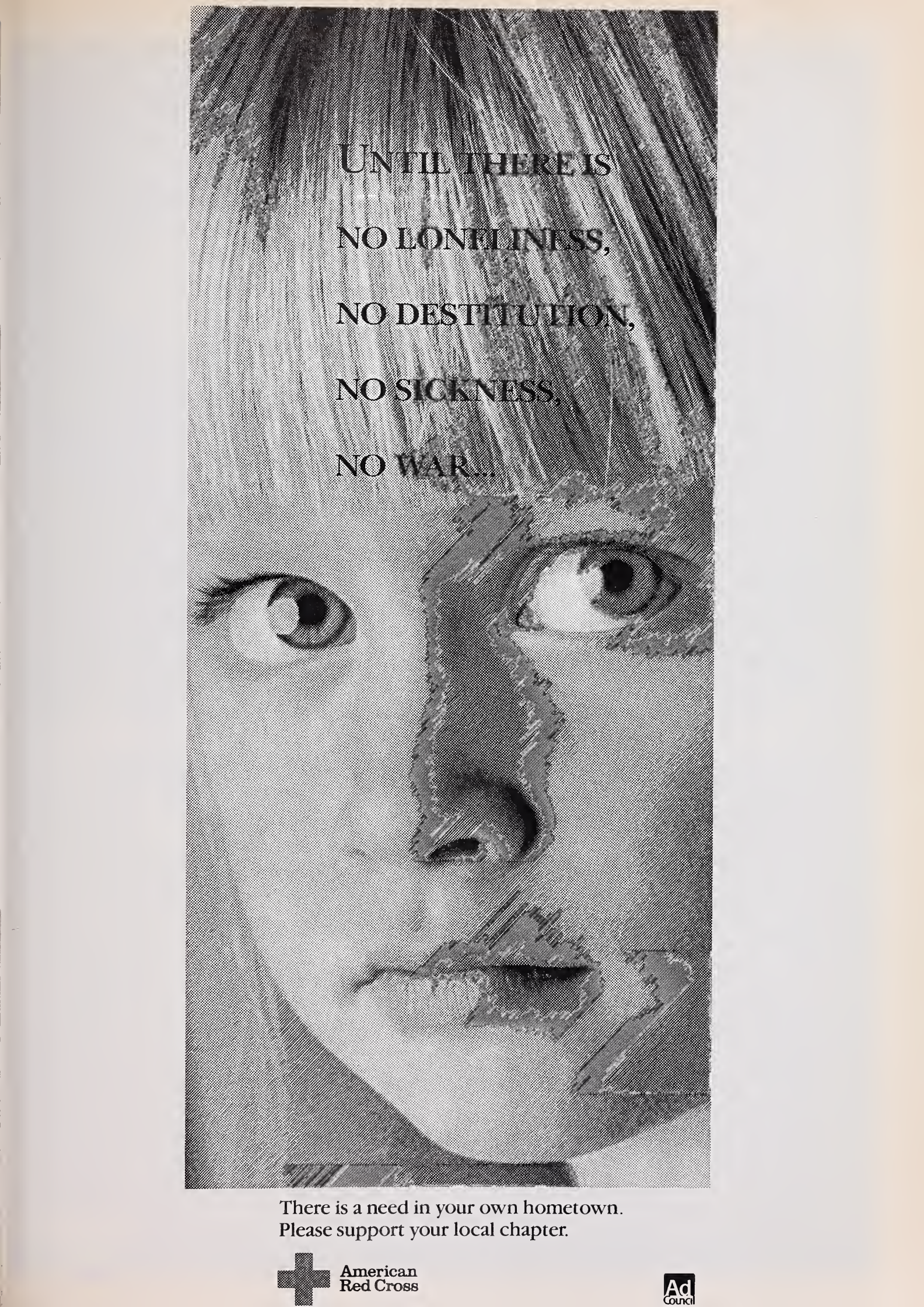
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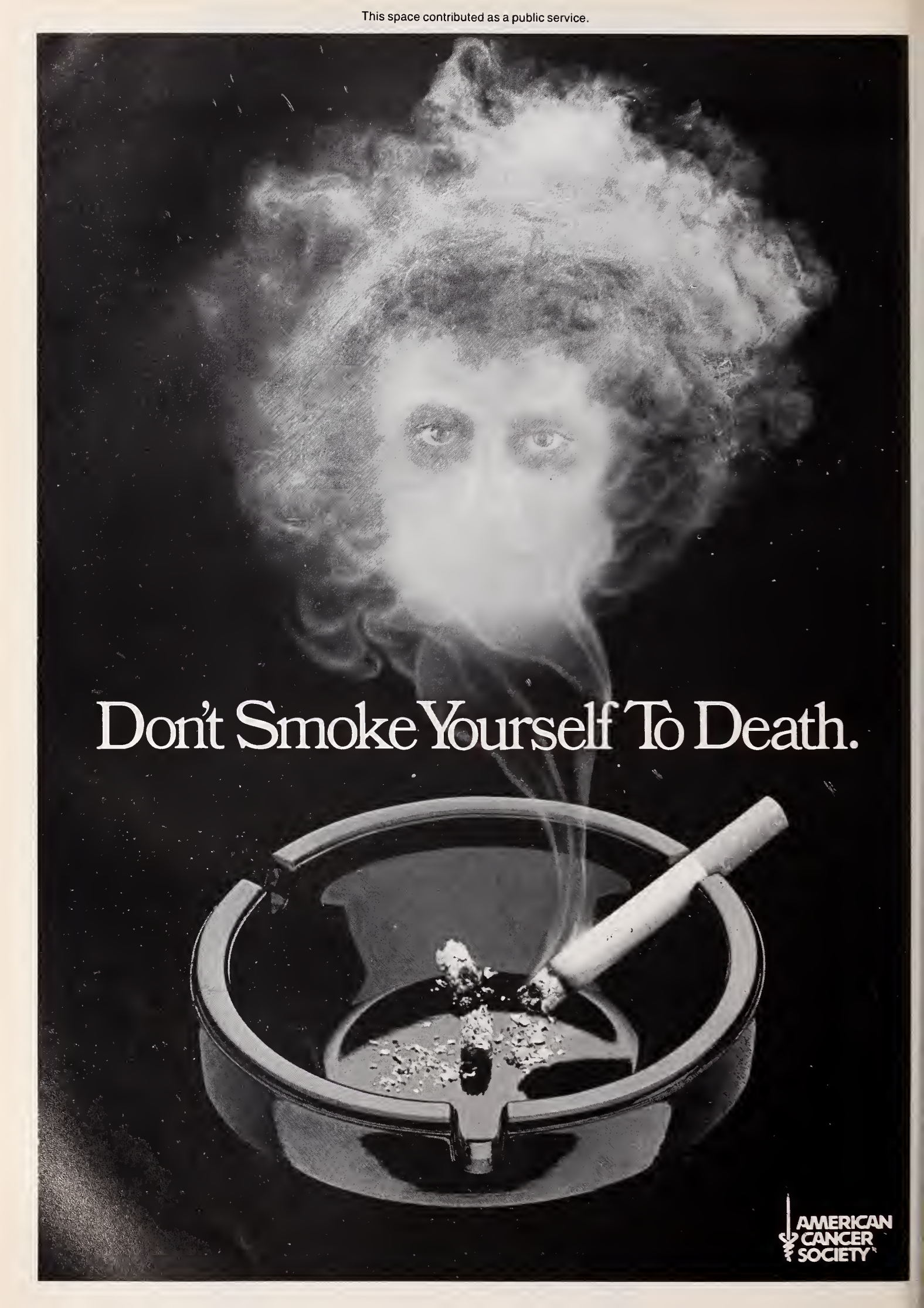
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# The Georgia Institute for the Prevention of Human Disease and Accidents

Maurice Levy, Ed.D., Frank A. Treiber, Ph.D., William B. Strong, M.D., Linda Musante, Ph.D.

**T**HE GEORGIA INSTITUTE for the Prevention of Human Disease and Accidents (the "Prevention Institute") was approved by the Board of Regents of the University System of Georgia and established at the Medical College of Georgia (MCG) in October, 1981. The stated purposes of the institute at its inception were as follows:

1. To provide an outstanding educational program for medical, dental, nursing, and allied health students and residents directed toward the prevention of human disease and accidents.

2. To conduct interdisciplinary scientific research in the areas of disease and accident prevention.

3. To promote individual responsibility for the maintenance and improvement of health in adults and children by emphasizing appropriate lifestyle behaviors.

4. To educate health professionals in teaching their patients preventive measures that will reduce disease and accidents.

5. To work cooperatively with national, state, and local agencies in assisting the public to adopt or continue health-centered lifestyles.

## Background

The prevention of disease is both essential and implicit in health care. The health-related discoveries with the broadest impact on human illness have been in the realm of prevention. The global eradication of smallpox, the virtual elimination of measles from the African continent, and the removal of poliomyelitis as a health threat exemplify preventive medicine at its best.

Today, the leading causes of death in the United States and most first world countries are chronic cardiovascular disease, cancer, and accidents — all of which appear to be highly correlated with lifestyle and environmental influences. The *prevention* of diseases and accidents can result in a significant decrease in medical costs to society, thereby providing economic bene-

fits beyond the inherent value of promoting healthy lifestyle behaviors.

## Resources

The Prevention Institute comprises four faculty members, five research assistants, a data manager, a visiting professor, an administrative specialist and a senior administrative secretary. Each of these individuals has his/her own expertise and talents that enhance the overall effectiveness of the organization. The current areas of expertise represented by the faculty and staff are preventive cardiology, nutrition, psychosocial data assessment, and physical activity/physical fitness measurements.

MCG appointments for faculty involved in Prevention Institute activities are made through the various departments within the four schools (Medicine, Dentistry, Nursing, and Allied Health). Therefore, promotion, tenure, and salary issues are handled within the individual schools and departments to which a particular faculty member belongs.

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Dr. Levy is Professor of Pediatrics, Dr. Treiber is Assistant Professor of Pediatrics and Psychiatry and Health Behavior, Dr. Strong is Charbonnier Professor of Pediatrics and Chief of the Section of Pediatric Cardiology, and Dr. Musante is Research Associate (on leave as Associate Professor of Psychology, University of Tampa), Medical College of Georgia. Send reprint requests to Dr. Levy at the Department of Pediatrics, Medical College of Georgia, Augusta, GA 30912.

The Prevention Institute is housed in a 3,150 square foot brick building recently purchased by the Medical College of Georgia and is located near the medical student residences and the Student Center. The Institute has 10 offices, a conference room, physical and psychological stress testing laboratories, and a fully equipped kitchen.

### **Activities**

The activities of the Prevention Institute can be categorized in the same manner as those of its parent institution, MCG. Those activities fall under the categories of Research, Education, and Service.

### **Research**

Two National Heart, Lung, and Blood Institute grants that have been awarded to faculty at the Prevention Institute are the principal sources of support for the Institute, although MCG has also provided substantial resources. The first grant, Studies of Children's Activities and Nutrition (SCAN), is in the 4th year of its 5 year projected funding period. The second grant, Essential Hypertension: Role of Race and Stress, began in December, 1988, is a 5 year First Award to study antecedents of hypertension. Additional grant applications will be submitted to funding agencies whose priorities are similar to those of the Prevention Institute.

The following is a brief synopsis of some of the findings by content area.

### **Physiological Studies**

The Sport Tester PE 3000 portable heart rate monitor was validated in both laboratory and field settings. The Sport Tester was found to be a practical inexpensive, reliable, and valid means of assessing heart rate in children across a number of settings with a variety of physical exercises. It should prove useful in research and applied settings with individuals as young as 4 years of age for whom heart rate monitoring is important.<sup>1</sup>

Previous studies have observed that black children exhibit greater blood pressure increase to dynamic exercise than do white children. We recently found in a sam-

## **Two National Heart, Lung, and Blood Institute grants that have been awarded to faculty at the Prevention Institute are the principal sources of support for the Institute, although MCG has also provided substantial resources.**

ple of 10-year-old boys that blacks exhibited higher levels of total peripheral resistance from pre-exercise throughout each workload compared to their white cohorts. The white boys exhibited greater cardiac output at each level of activity. A trend toward greater blood pressure increases in the black boys was noted which appeared to be due to less attenuation of total peripheral resistance rather than the expected increases in cardiac output.<sup>2</sup>

**R**acial differences in young children's blood pressure responses to treadmill exercise were recently examined. The findings indicate that in 4 to 6-year-old children, blacks exhibited greater systolic blood pressure increases than whites.<sup>3</sup> These findings corroborate outcomes of previous studies which involved older children and adults.

Several studies in young adults have indicated that blacks show greater cardiovascular reactivity to alpha adrenergic mediated stress than whites (e.g., forehead cold stimulation). Recent findings from the Prevention Institute stress laboratory have shown that among black boys, 11 to 14 years of age, those with a positive family history of essential hypertension exhibited greater increases in diastolic blood pressure to forehead cold stimulation than their cohorts who had a negative family history of essential hypertension.<sup>7</sup> Again, these differences in blood pressure reactivity were due to greater increases in total peripheral resistance. Collectively, findings from these reactivity

studies are important because the exaggerated cardiovascular reactivity of blacks may partially account for the well established racial differences in the incidence of essential hypertension and its associated morbidity and mortality.

### **Physical Activity/Health Related Physical Fitness**

Prospective studies with adults have indicated that greater levels of habitual physical activity are associated with decreased incidence of cardiovascular diseases. Little is known about this relationship in children. Using a sample of 10-year-old white children, we examined the relationship between parental reports of the children's physical activity to response to a supine cycleergometer exercise. Findings indicated that children who are less physically active weighed slightly more than the high physical activity group, but no differences were noted in height or body surface area. The low physical activity group had greater heart rate, systolic blood pressure, cardiac output, and rate pressure product. They also showed a trend toward greater cardiac index and lower peripheral resistance at pre-exercise. Comparisons at maximal exercise found the less physically active group to have greater mean arterial pressure and systolic blood pressure. The more physically active group showed greater duration of exercise.<sup>4</sup> These findings confirm the early relationship between physical activity levels and children's physical fitness and associated cardiovascular risk indices.

### **Psychosocial Factors**

Hostility appears to be the component of Type A behavior pattern that is a strong contributor to coronary artery disease. We recently adapted brief versions of two hostility scales that have been used with adults and have been associated with severity of arterial occlusion. Using a sample of 88 children 6 to 10 years of age, we found that these modified scales exhibited adequate psychometric properties and that hostility was associated with children's resting blood pressure.<sup>5</sup>



We have been evaluating the early development of the Type A behavior pattern in children. Recent findings indicate that in preschool-aged children, Type A behavior pattern depends on an interaction of family history of coronary artery disease and parental hostility.<sup>6</sup> That is, children from families with positive histories of coronary artery disease who also had mothers who reported frequent overt expression of hostility and anger exhibited higher scores on the impatience/aggression component of a Type A behavior scale. These findings indicate the complex relationship between Type A behavior and the early influence of family members.

#### Nutrition

The accurate evaluation of young children's dietary habits is an important methodologic issue in the assessment of the early development of lifestyle-related behaviors associated with cardiovascular diseases. Children's dietary intake varies considerably from day to day and thus a food frequency questionnaire might be useful in reflecting food intake patterns over longer periods of time. Such forms have not been used with preschool-aged children. We have recently examined the test-retest reliabilities of a 3-month food-frequency questionnaire and the 24 hour recall with parental reports of their preschool children's nutrient intakes.<sup>8</sup> Findings corroborating other studies indicating there was significant variability in the two sets of 24 hour recalls which were separated by a 1 week interval. However, several nutrients were found to be stable across this time including polyunsaturated fat, cholesterol, and total carbohydrates. On the other hand, the food frequency questionnaire was found to exhibit significant correlations between the two reports on all categories of nutrients. These findings indicate that due to significant variability in day to day food intake of preschool aged children, food frequency questionnaires that obtain dietary information over longer periods of time may be more useful in health research than 24 hour recall measures. However, 24

hour recalls appear to be useful in the assessment of specific nutrient changes across shorter durations of time. Further work is underway examining the validity of the 3-month food frequency questionnaire with this age range of children.

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### **The prevention of diseases and accidents will result in a significant decrease in medical costs to society, thereby providing additional benefits beyond the inherent value of promoting healthy lifestyle behaviors.**

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#### *Education*

The Students for Community Involvement (SCI) Program is the educational arm of the Prevention Institute.<sup>9</sup> SCI, which is in its 10th year, was implemented as an integral component of the Preventive Cardiology Academic Award, a National Heart, Lung, and Blood Institute funded grant. It has continued through internal funding from MCG. SCI is the most heavily subscribed elective course in the School of Medicine. During the past 10 years, over 550 medical students have learned the basic elements of preventive cardiology (including, nutrition, anti-smoking, natural history of atherosclerosis, and physical fitness). In turn, they have taught these principles to more than 20,000 sixth grade students in the local public schools.

The medical students enrolled in SCI attend 15 1-hour sessions that occur biweekly at noon. MCG faculty and visiting professors present a cardiovascular risk factor curriculum that will have future impact on both the medical students and their sixth grade students. The final activity is the actual teaching phase where the medical students present

the preventive cardiology topics to children in the local public schools. Each medical student is expected to present two to three classroom sessions.

In addition to SCI, two faculty members from other universities have taken their sabbatical year with the Prevention Institute. Both faculty members contributed significantly to the Institute and enhanced their professional development through their interaction with faculty and staff.

#### *Service*

A Family Cardiac Risk Reduction Clinic has recently been implemented to provide patient care services to families who have been identified to be at high risk for cardiovascular disease based on family health histories and cholesterol screening. An individualized intervention program is designed for each family through the collaborative efforts of two internists, a pediatric preventive cardiologist, and a nutritionist. This Clinic is an outstanding example of preventive cardiology/lifestyle modification in action as well as interdepartmental collaboration. Referral of children and their families for evaluation in the various laboratories of the Georgia Prevention Institute is available.

Another example of collaboration, but on the national level, is one in which a Prevention Institute faculty member collaborated with experts from the American Health Foundation to produce a monograph detailing the means by which pediatric preventive cardiology can be implemented in the physician's office setting. It establishes guidelines for office cholesterol screening. Based on the recommendations, many hypercholesterolemic patients have been identified after screening of their children.

The Prevention Institute encourages and participates in collaborative programs across department and school boundaries. In the recent past, for example, Prevention Institute faculty brought together other faculty from the Schools of Dentistry and Medicine whose combined efforts resulted in a funded grant.

### **Institutional Support**

In 1985, the former President of MCG presented a master plan for the growth and development of the MCG to all constituencies of the institution. One of the areas of that plan identified as having high priority was health promotion/disease prevention.

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**The practicing physician has and will continue to benefit in many ways from the activities of the Prevention Institute. The medical students and physicians who have completed the Students for Community Involvement Elective course are prevention oriented, and some have organized or been significantly involved in their own community programs.**

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**T**he administration of the Medical College has made a commitment to assist the Prevention Institute to achieve its goals and

objectives of promoting health and preventing diseases and accidents. By providing the Institute with a building, salaries for personnel, and necessary equipment, MCG has both encouraged and aided in the achievement of numerous accomplishments that would otherwise have been difficult.

### **Conclusion**

The practicing physician has and will continue to benefit in many ways from the activities of the Prevention Institute. The medical students and physicians who have completed the Students for Community Involvement Elective course are prevention oriented, and some have organized or been significantly involved in their own community programs. One medical graduate has organized a group of high school students in the North Carolina community where he is practicing to learn basic concepts of preventive cardiology and teach those concepts to elementary school children in their community.

The research activities at the Prevention Institute will help provide answers to major lifestyle behavior questions that significantly influence the health of patients. Areas of investigation that most likely will be of greatest interest to physicians in practice are nutrition and exercise-related studies. The results will demonstrate the importance of these behaviors as well as the means to identify the individual at risk and implement appropriate interventions.

**T**he Prevention Institute can provide information to physicians on state-of-the-art health promotion/disease prevention activities. Physicians who are interested in any of the aspects of Prevention Institute activities or health promotion programs/findings at other institutions can either contact the Prevention Institute at the address listed above or by phone at (404) 721-4534.

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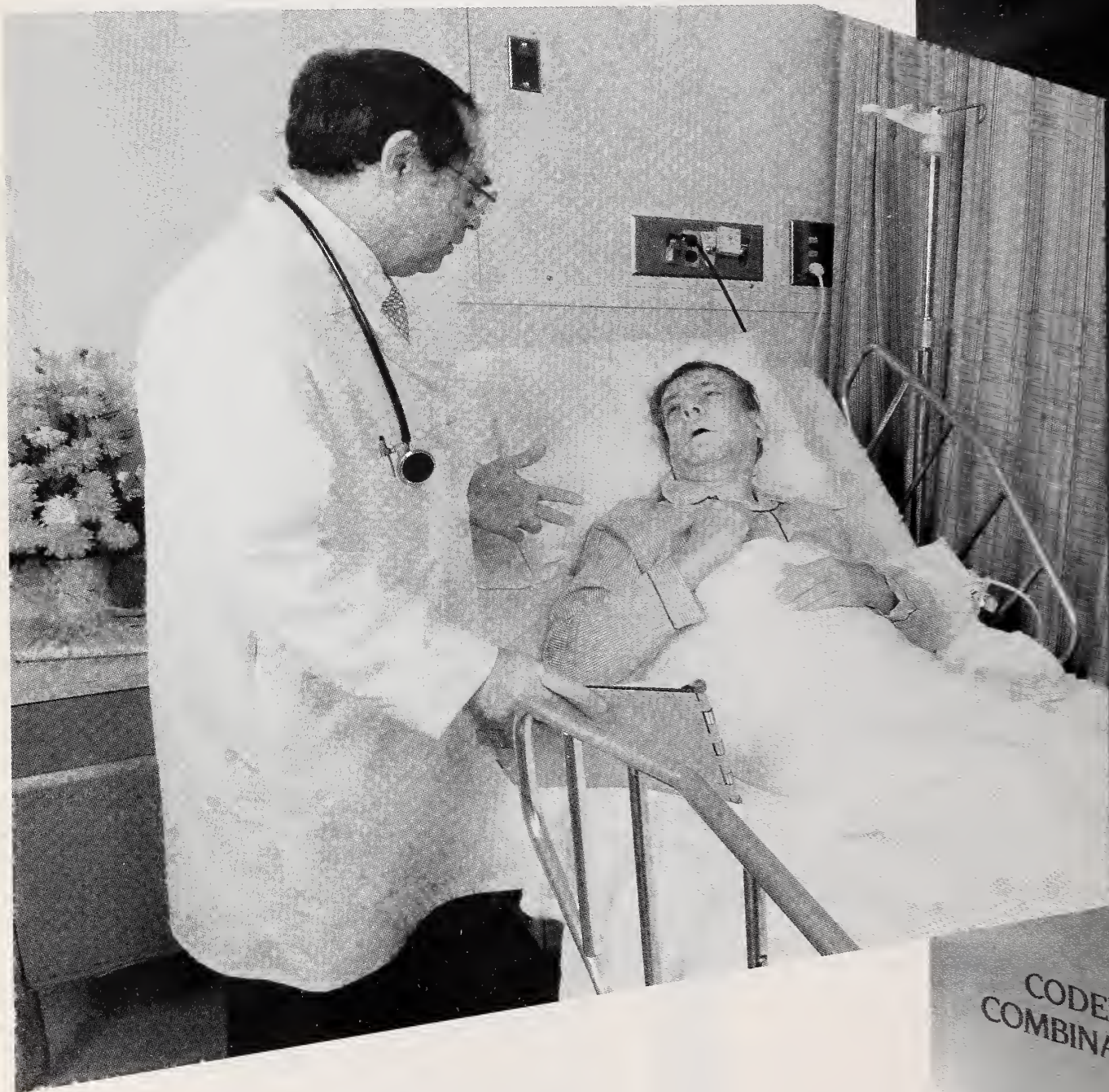
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Meperidine hydrochloride is ethyl 1-methyl-4-phenylisopropylate hydrochloride, a white crystalline substance with a melting point of 186°C to 189°C. It is readily soluble in water and has a neutral reaction and a slightly bitter taste. The solution is not decomposed by a short period of boiling.

The syrup is a pleasant-tasting, nonalcoholic, banana-flavored solution containing 50 mg of DEMEROL hydrochloride, brand of meperidine hydrochloride, per 5 mL teaspoon (25 drops contain 13 mg of DEMEROL hydrochloride). The tablets contain 50 mg or 100 mg of the analgesic.

DEMOROL hydrochloride injectable is supplied in Carpuject® Sterile Cartridge-Needle Unit of 2.5% (25 mg/1 mL), 5% (50 mg/1 mL), 7.5% (75 mg/1 mL), and 10% (100 mg/1 mL). Uni-Amp® Unit Dose Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Uni-Nest™ Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Multiple-dose vials of 5% and 10% solutions contain metacresol 0.1% as preservative.

The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid.

DEMOROL hydrochloride, brand of meperidine hydrochloride, 5 percent solution has a specific gravity of 1.0086 at 20°C and 10 percent solution, a specific gravity of 1.0165 at 20°C.

**Inactive Ingredients** — TABLETS: Calcium Sulfate, Dibasic Calcium Phosphate, Starch, Stearic Acid, Talc. SYRUP: Benzoic Acid, Flavor, Liquid Glucose, Purified Water, Saccharin Sodium.

## CLINICAL PHARMACOLOGY

Meperidine hydrochloride is a narcotic analgesic with multiple actions qualitatively similar to those of morphine, the most prominent of these involve the central nervous system and organs composed of smooth muscle. The principal actions of therapeutic value are analgesia and sedation.

There is some evidence which suggests that meperidine may produce less smooth muscle spasm, constipation, and depression of the cough reflex than equianalgesic doses of morphine. Meperidine, in 60 mg to 80 mg parenteral doses, is approximately equivalent in analgesic effect to 10 mg of morphine. The onset of action is slightly more rapid than with morphine, and the duration of action is slightly shorter. Meperidine is significantly less effective by the oral than by the parenteral route, but the exact ratio of oral to parenteral effectiveness is unknown.

## INDICATIONS AND USAGE

For the relief of moderate to severe pain (parenteral and oral forms)  
For preoperative medication (parenteral form only)  
For support of anesthesia (parental form only)  
For obstetrical analgesia (parental form only)

## CONTRAINDICATIONS

Hypersensitivity to meperidine.

Meperidine is contraindicated in patients who are receiving monoamine oxidase (MAO) inhibitors or those who have recently received such agents. Therapeutic doses of meperidine have occasionally precipitated unpredictable, severe, and occasionally fatal reactions in patients who have received such agents within 14 days. The mechanism of these reactions is unclear, but may be related to a preexisting hyperphenylalaninemia. Some have been characterized by coma, severe respiratory depression, cyanosis, and hypotension, and have resembled the syndrome of acute narcotic overdose. In other reactions the predominant manifestations have been hyperexcitability, convulsions, tachycardia, hyperpyrexia, and hypertension. Although it is not known that other narcotics are free of the risk of such reactions, virtually all of the reported reactions have occurred with meperidine. If a narcotic is needed in such patients, a sensitivity test should be performed in which repeated, small, incremental doses of morphine are administered over the course of several hours while the patient's condition and vital signs are under careful observation. (Intravenous hydrocortisone or prednisolone have been used to treat severe reactions, with the addition of intravenous chlorpromazine in those cases exhibiting hypertension and hyperpyrexia. The usefulness and safety of narcotic antagonists in the treatment of these reactions is unknown.)

Solutions of DEMEROL and barbiturates are chemically incompatible.

## WARNINGS

**Drug Dependence.** Meperidine can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of meperidine, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Like other narcotics, meperidine is subject to the provisions of the Federal narcotic laws.

**Interaction with Other Central Nervous System Depressants.** MEPERIDINE SHOULD BE USED WITH GREAT CAUTION AND IN REDUCED DOSAGE IN PATIENTS WHO ARE CONCURRENTLY RECEIVING OTHER NARCOTIC ANALGESICS, GENERAL ANESTHETICS, PHENOTHIAZINES, OTHER TRANQUILIZERS (SEE DOSAGE AND ADMINISTRATION), SEDATIVE-HYPNOTICS (INCLUDING BARBITURATES), TRICYCLIC ANTIDEPRESSANTS AND OTHER

CNS DEPRESSANTS (INCLUDING ALCOHOL). RESPIRATORY DEPRESSION, HYPOTENSION, AND PROFOUND SEDATION OR COMA MAY RESULT.

**Head Injury and Increased Intracranial Pressure.** The respiratory depressant effects of meperidine and its capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. In such patients, meperidine must be used with extreme caution and only if its use is deemed essential.

**Intravenous Use.** If necessary, meperidine may be given intravenously, but the injection should be given very slowly, preferably in the form of a diluted solution. Rapid intravenous injection of narcotic analgesics, including meperidine, increases the incidence of adverse reactions; severe respiratory depression, apnea, hypotension, peripheral circulatory collapse, and cardiac arrest have occurred. Meperidine should not be administered intravenously unless a narcotic antagonist and the facilities for assisted or controlled respiration are immediately available. When meperidine is given parenterally, especially intravenously, the patient should be lying down.

**Asthma and Other Respiratory Conditions.** Meperidine should be used with extreme caution in patients having an acute asthmatic attack, patients with chronic obstructive pulmonary disease or cor pulmonale, patients having a substantially decreased respiratory reserve, and patients with preexisting respiratory depression, hypoxia, or hypercapnia. In such patients, even usual therapeutic doses of narcotics may decrease respiratory drive while simultaneously increasing airway resistance to the point of apnea.

**Hypotensive Effect.** The administration of meperidine may result in severe hypotension in the postoperative patient or any individual whose ability to maintain blood pressure has been compromised by a depleted blood volume or the administration of drugs such as the phenothiazines or certain anesthetics.

**Usage in Ambulatory Patients.** Meperidine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient should be cautioned accordingly.

Meperidine, like other narcotics, may produce orthostatic hypotension in ambulatory patients.

**Usage in Pregnancy and Lactation.** Meperidine should not be used in pregnant women prior to the labor period, unless in the judgment of the physician the potential benefits outweigh the possible hazards, because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development.

When used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce depression of respiration and psychophysiological functions in the newborn. Resuscitation may be required (see section on **OVERDOSAGE**).

Meperidine appears in the milk of nursing mothers receiving the drug.

## PRECAUTIONS

As with all intramuscular preparations DEMEROL intramuscular injection should be injected well within the body of a large muscle.

**Supraventricular Tachycardias.** Meperidine should be used with caution in patients with atrial flutter and other supraventricular tachycardias because of a possible vagolytic action which may produce a significant increase in the ventricular response rate.

**Convulsions.** Meperidine may aggravate preexisting convulsions in patients with convulsive disorders. If dosage is escalated substantially above recommended levels because of tolerance development, convulsions may occur in individuals without a history of convulsive disorders.

**Acute Abdominal Conditions.** The administration of meperidine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special Risk Patients.** Meperidine should be given with caution and the initial dose should be reduced in certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

## ADVERSE REACTIONS

The major hazards of meperidine, as with other narcotic analgesics, are respiratory depression and, to a lesser degree, circulatory depression; respiratory arrest, shock, and cardiac arrest have occurred.

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea, vomiting, and sweating. These effects seem to be more prominent in ambulatory patients and in those who are not experiencing severe pain. In such individuals, lower doses are advisable. Some adverse reactions in ambulatory patients may be alleviated if the patient lies down.

Other adverse reactions include:

**Nervous System.** Euphoria, dysphoria, weakness, headache, agitation, tremor, uncoordinated muscle movements, severe convulsions, transient hallucinations and disorientation, visual disturbances. Inadvertent injection about a nerve trunk may result in sensory-motor paralysis which is usually, though not always, transitory.

**Gastrointestinal.** Dry mouth, constipation, biliary tract spasm.

**Cardiovascular.** Flushing of the face, tachycardia, bradycardia, palpitation, hypotension (see Warnings), syncope, phlebitis following intravenous injection.

**Genitourinary.** Urinary retention.

**Allergic.** Pruritus, urticaria, other skin rashes, wheal and flare over the vein with intravenous injection.

**Other.** Pain at injection site; local tissue irritation and induration following subcutaneous injection, particularly when repeated; anti-diuretic effect.

## DOSAGE AND ADMINISTRATION

### For Relief of Pain

Dosage should be adjusted according to the severity of the pain and the response of the patient. While subcutaneous administration is suitable for occasional use, intramuscular administration is preferred when repeated doses are required. If intravenous administration is required, dosage should be decreased and the injection made

very slowly, preferably utilizing a diluted solution. Meperidine is less effective orally than on parenteral administration. The dose of DEMEROL should be proportionately reduced (usually by 25 to 50 percent) when administered concomitantly with phenothiazines and many other tranquilizers since they potentiate the action of DEMEROL.

**Adults.** The usual dosage is 50 mg to 150 mg intramuscularly, subcutaneously, or orally, every 3 or 4 hours as necessary.

**Children.** The usual dosage is 0.5 mg/lb to 0.8 mg/lb intramuscularly, subcutaneously, or orally up to the adult dose, every 3 or 4 hours as necessary.

Each dose of the syrup should be taken in one-half glass of water, since if taken undiluted, it may exert a slight topical anesthetic effect on mucous membranes.

### For Preoperative Medication

**Adults.** The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously, 30 to 90 minutes before the beginning of anesthesia.

**Children.** The usual dosage is 0.5 mg/lb to 1 mg/lb intramuscularly or subcutaneously up to the adult dose, 30 to 90 minutes before the beginning of anesthesia.

### For Support of Anesthesia

Repeated slow intravenous injections of fractional doses (eg, 10 mg/mL) or continuous intravenous infusion of a more dilute solution (eg, 1 mg/mL) should be used. The dose should be titrated to the needs of the patient and will depend on the premedication and type of anesthesia being employed, the characteristics of the particular patient, and the nature and duration of the operative procedure.

### For Obstetrical Analgesia

The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously when pain becomes regular, and may be repeated at 1- to 3-hour intervals.

## OVERDOSAGE

**Symptoms.** Serious overdosage with meperidine is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

**Treatment.** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonist, naloxone hydrochloride, is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including meperidine. Therefore, an appropriate dose of this antagonist should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

In cases of overdosage with DEMEROL tablets, the stomach should be evacuated by emesis or gastric lavage.

**NOTE:** In an individual physically dependent on narcotics, the administration of the usual dose of a narcotic antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of narcotic antagonists in such individuals should be avoided if possible. If a narcotic antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care and only one-fifth to one-tenth the usual initial dose administered.

## HOW SUPPLIED

### For Parenteral Use

**Detecto-Seal® — Carpuject® Sterile Cartridge-Needle Unit —** 2.5 percent (25 mg per 1 mL) **NDC 0024-0324-02**, 5 percent (50 mg per 1 mL) **NDC 0024-0325-02**, 7.5 percent (75 mg per 1 mL) **NDC 0024-0326-02**; and 10 percent (100 mg per 1 mL) **NDC 0024-0328-02** all in boxes of 10.

Each cartridge is only partially filled based upon product volume to permit mixture with other sterile materials in accordance with the best judgment of the physician.

**Uni-Amp® — 5 percent solution;** ampuls of 0.5 mL (25 mg) **NDC 0024-0361-04**, 1 mL (50 mg) **NDC 0024-0362-04**, 1½ mL (75 mg) **NDC 0024-0363-04**, and 2 mL (100 mg) **NDC 0024-0364-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0365-04** in boxes of 25.

**Uni-Nest™ — 5 percent solution;** ampuls of 0.5 mL (25 mg) **NDC 0024-0371-04**, 1 mL (50 mg) **NDC 0024-0372-04**, 1½ mL (75 mg) **NDC 0024-0373-04**, and 2 mL (100 mg) **NDC 0024-0374-04** all in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) **NDC 0024-0375-04** in boxes of 25.

**Vials — 5 percent multiple-dose vials** of 30 mL **NDC 0024-0329-01** and 10 percent multiple-dose vials of 20 mL **NDC 0024-0331-01** all in boxes of 1.

**Note:** The pH of DEMEROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid. Multiple-dose vials contain metacresol 0.1 percent as preservative. No preservatives are added to the ampuls or CARPUJECT Sterile Cartridge-Needle Unit.

### For Oral Use

**Tablets** of 50 mg, bottles of 100 (**NDC 0024-0335-04**) and 500 (**NDC 0024-0335-06**); Hospital Blister Pak of 25 (**NDC 0024-0335-02**) 100 mg, bottles of 100 (**NDC 0024-0337-04**) and 500 (**NDC 0024-0337-06**); Hospital Blister Pak of 25 (**NDC 0024-0337-02**).

**Syrup**, nonalcoholic, banana-flavored 50 mg per 5 mL teaspoon, bottles of 16 fl oz (**NDC 0024-0332-06**).

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**Winthrop**  
PHARMACEUTICALS

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# The Three Rs: Reflection, Renewal, Reforms

W. Daniel Barker

## Introduction

**A**LTHOUGH DIFFERENT from the three Rs to which we usually refer — reading, 'riting, and 'rithmetic — the three Rs to which I refer today are equally important — reflection, renewal, and reforms.

As you know, this is the 60th anniversary of the Georgia Hospital Association. Our meeting theme is "Three-Score and More." Yesterday morning, the opening session featured an outstanding review of our history. The year 1929 was an eventful one. On February 14, the St. Valentine's Day massacre took place in Chicago when gangsters killed seven rivals to gain greater control of the underworld. On June 15, the Agricultural Marketing Act was passed and as a result of that legislation, the concept of stable prices for farm products was established. On October 29, the stockmarket crash took place and the Great Depression began. In between, Thomas Wolfe published *Look Homeward Angel* and William Faulkner published *The Sound and the Fury*. Many things happened in 1929, not just the organization of the Georgia Hospital Association.

Nineteen twenty-nine seems like a long time ago. How long ago was

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**In 1949, representatives from the United Hospital Service Association in Atlanta and the Blue Cross Plan in Columbus requested support from GHA in amending the current laws in Georgia which specifically prohibited voluntary pre-payment plans from soliciting subscribers outside of a radius of 50 miles from their respective central offices.**

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it? To paraphrase an advertisement originally printed in the *Mines Magazine* and reprinted in the *Reader's*

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*Digest* over 15 years ago: "Wanted: Man to work on nuclear fissionable isotope molecular reactive counters and three-phase cyclotronic uranium photosynthesizers. No experience necessary."

- That was before birth control pills and the population explosion,
- Before television, the mass production of penicillin, polio shots, antibiotics, and Frisbees.
- Before frozen foods, nylon, Dacron, Xerox, and the Kinsey Report.
- It was also before radar, fluorescent lights, credit cards, and ball point pens.
- Time sharing meant togetherness, not computers, and a chip meant a piece of wood. Hardware meant hardware and software wasn't even a word.
- It was before pantyhose and drip-dry clothes.
- Before icemakers, dishwashers, clothes dryers, freezers, and electric blankets.
- And before men wore long hair and earrings and before women wore jockey shorts and tuxedos.

Almost everything has changed since 1929, but in no area of American life has progress been greater than in health care.

## REFLECTION

The first R — REFLECTION. As we look back to our history, our roots, the idea for a Georgia hospital association came from our physician friends in the Medical Association of Georgia.

On February 6, 1929, at 10 a.m. in Macon, the organizational meeting of the Georgia Hospital Association (GHA) took place. The speed with which the GHA was organized is indicative of the role which everyone looked forward to its fulfilling. Less than a year earlier, in May of 1928, the Medical Association of Georgia in its annual session in Savannah, instructed its Committee on Hospitals to proceed with the organization of a state hospital association and appointed an organizational committee comprised of the following members: Dr. Carlisle S. Lentz, Superintendent of University Hospital, Augusta as chairman; Dr. Grady N. Coker, Coker Hospital, Canton, Secretary; Dr. G. F. Klugh, Atlanta; Dr. J. K. Quattlebaum, Savannah; and Dr. B. F. Wise, from Plains. By October, 1928, the idea for a hospital association received groundswell support from this committee and in less than 6 months, the Georgia Hospital Association would become a reality. Thirty people from 16 different hospitals throughout the state were in attendance. The initial officers of the Georgia Hospital Association were Dr. Joe R. Clements, President; Dr. Carlisle S. Lentz, First Vice President; and Ms. Jane Vandevrede, Second Vice President; and Mr. J. B. Franklin, Secretary-Treasurer. Ms. Vandevrede raised the question of her eligibility to serve, inasmuch as she was not directly connected with any hospital but rather was Secretary of the Board of Examiners of Nurses for Georgia. This question was left in abeyance until a committee on constitution and bylaws could be appointed and bring in a report.

During their organizational meeting, Dr. Sharp from Arlington, Georgia, and President of the Medical Association of Georgia, discussed community medicine, the small community hospital, and the service this association could render

small hospitals. Dr. Lentz commented on the urgent need of more county hospitals and of an amendment to the Georgia Workman's Compensation law and other things.

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**At the 1941 meeting of the Georgia Hospital Association, it was decided that it would be in the best interests of both the MAG and GHA to get together and confer on all proposed legislation before any action was taken by either group.**

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Dr. Charles H. Richardson from Macon urged the Georgia Hospital Association to give special study to the needs of small hospitals. Ms. Vandevrede gave as one very important function of this association the dissemination of information concerning the various hospitals of the state to the end that the larger and stronger hospitals may serve and help the smaller and weaker hospitals. Dr. Grady Coker spoke on the daily per capita cost and upkeep emphasizing that the care of patients is expensive.

Three months later, on May 6, 1929, the first annual meeting of the Georgia Hospital Association was held in the city auditorium in Macon. Among the topics discussed at the first annual convention were the following: the problems of small hospitals, why so many changes in hospital executives and training school personnel, needed hospital legislation in Georgia, minimum standards for organization of community hospitals of 20 to 40 beds. In addition, roundtable discussions were conducted on administrative problems which, according to the minutes of that meeting, proved to be very in-

teresting and helpful. Also, then as today, the Executive Secretary (now President) of the American Hospital Association in Chicago was present and discussed the administrative problems facing hospitals. Dr. Burt W. Caldwell was the Executive Secretary at the time. That first annual meeting reconvened at 8 p.m. for further discussions. Ms. Jane Vandevrede was first on the program and presented a paper entitled "The Future of the Small Schools of Nursing in Georgia." Miss Alice Stewart of the University Hospital in Augusta then conducted a roundtable on nursing problems.

Also at that first annual meeting, in addition to Dr. Carlisle S. Lentz as President, Ms. Annie Bess Feedback was elected First Vice President, Dr. Albert S. Saunders was elected Second Vice President, and Mr. J. B. Franklin was elected Treasurer. It was also unanimously agreed, that effective January 1, 1930, the Georgia Hospital Association would become a geographical section of the American Hospital Association and membership in the Georgia Hospital Association would carry with it membership in the AHA without additional dues.

Special called meetings of the Georgia Hospital Association are nothing new. On July 9, 1931, a special meeting was called that Thursday evening at Grady Hospital to discuss legislative concerns. As a result, a committee on legislation was appointed to sponsor favorable measures and otherwise take steps to safeguard the interest of hospitals. Mr. Robert Hudgins of Emory University Hospital was appointed chairman. Mr. W. D. Barker, Georgia Baptist Hospital, Atlanta; Dr. Grady N. Coker, Coker Hospital, Canton; Dr. Luther C. Fischer, Davis-Fischer Sanatorium, Atlanta; and Ms. Jane Vandevrede, Secretary of the State Board for Nurse Examiners, Atlanta, comprised this membership.

On August 5, 1938, another special meeting of the Georgia Hospital Association was convened in Atlanta at the Academy of Medicine. This meeting was called by



Dr. Fischer at the request of Governor Rivers to consider the future needs of the hospitals of the state and also group hospitalization. The following action was unanimously approved:

(1) That the various government organizations approve the idea of the building of county hospitals at points in the state where surveys indicate the need. This activity could be done either singularly or by groups of counties.

(2) That competent surveys be made to determine such strategic points.

(3) That public officials and citizens be fully instructed concerning their financial responsibilities for the operation of such hospitals.

(4) That the constitution and laws of the State of Georgia be modified so that counties and other subdivisions can legally spend money for hospitalization for their indigent sick.

**A**t the annual meeting of the Georgia Hospital Association in 1941, it was decided that it would be in the best interests of both the Medical Association of Georgia and the Georgia Hospital Association to get together and confer on all proposed legislation before any action was taken by either group. This resulted because of the recent defeat of a bill to amend the hotel law in Georgia to extend to hospitals the privilege to hold baggage, etc. just as hotels enjoyed. This bill was killed by three votes of members who were against any bill for any hospital. It was also decided that there would be general discussions throughout the year as well as occasional meetings with representatives of the Medical Association of Georgia on items of mutual interest. It was also agreed that it would be advantageous to meet with members of the Georgia State Nurses Association as well.

By 1947, the Association had grown to include 49 institutional members and 57 personal members.

The first annual meeting of the Georgia Hospital Association I was privileged to attend was in February, 1949. Mr. Robert F. Whitaker,

Superintendent of Emory University Hospital and President-Elect of GHA, gave an interesting report on a recent mid-year conference of the American Hospital Association in which he stressed the following points:

(1) The public is very health conscious, and there is insistence that better arrangements shall be made in regard to medical and hospital care.

(2) There is need of proper evaluation of the adequacy and effectiveness of the present health care programs.

(3) Hospital associations throughout the country are endeavoring to improve the quality of care of the sick, the efficiency of the hospital management, and the soundness of financial support.

(4) There is special concern at present with reference to the inadequate payment of cost of care rendered to medically indigent patients.

(5) Any federal compulsory insurance plan contains the prospect of sacrifices in the quality of medical care.

Also at that meeting, Mr. C. J. Anderson, with United Hospital Service Association in Atlanta, and Mr. Sam Butler, from the Blue Cross Plan in Columbus, requested support in amending current laws in Georgia which specifically prohibited voluntary pre-payment plans from soliciting subscribers outside of a radius of 50 miles from their respective central offices. This 50-mile rule limitation action was approved unanimously and soon became Georgia law. As a result, the 22 different not-for-profit hospitalization plans throughout Georgia rapidly consolidated into three Blue Cross plans and a few other not-for-profit plans. Today, we have one statewide Blue Cross/Blue Shield Plan and, I believe, one independent not-for-profit plan, the Griffin Hospital Care Association.

In reviewing the files of the Georgia Hospital Association, I ran across a copy of the last letter I wrote to our membership as President of the Georgia Hospital Association on March 20, 1968. Permit me to read parts of that letter:

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**At the state level,  
we must step up our  
efforts as far as  
improving our  
Medicaid coverage is  
concerned, both from  
the standpoint of  
payment as well as  
from the standpoint of  
people served.**

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"In the years since 1929, when the Georgia Hospital Association was organized, we have seen the path of service which was started become a highway of progress. All of us are indebted to the efforts of those who have gone on before us to bring to us this period in our associational life. Our challenge today is to continue this work so ably begun. Our responsibility is to assist in making the present highway of service into an expressway of health care. This can only be accomplished by an even stronger Georgia Hospital Association and closer liaison with other agencies, associations, and organizations who are our partners in the health field. Each member institution shares a great part of this responsibility because in the final analysis, the real accomplishments are those which result in better health care.

"As comprehensive planning receives more emphasis and the Georgia Regional Medical Program Task Force recommendations become implemented, we will have an even better foundation on which to build a health care system that will provide the citizens of this great state the finest in health care.

"The financing of health care is always an important factor because it is impossible to give adequate care without adequate financing. It is our hope that the Medicaid program in our state will broaden its scope to assist all who are medically indigent as soon as possible. The combination of pre-payment coverage, hospitalization insur-



ance, Medicare and Medicaid programs can provide a financial framework within which our voluntary hospital system can not only survive but become even stronger. This will only be possible if the providers of service receive a fair and adequate reimbursement from state and federal governments.

"As recruitment efforts receive more attention and the new Health Careers Council of Georgia becomes organized, it is anticipated that many of the budgeted vacancies which now exist in our health care institutions will be filled.

"This is a more strategic time because we are at the crossroads of our health care system. The direction that we take may well determine the future of health care in our nation."

Now, 21 years later, health planning and Certificate of Need matters are still before us, the financing of health care is an even greater factor and our Medicaid program is still inadequate. Although many improvements have been made in working conditions, salary, and recruitment activities, we still have personnel shortages.

During these past 60 years, many changes have taken place — significant programs on many different fronts have occurred. However, the main basic areas of concern are pretty much the same — cost, personnel shortages, inadequate financing, lack of understanding of our mission by our elected officials, etc.

**I**t is also interesting to review the object of the Georgia Hospital Association as recorded in its initial Constitution and By-laws:

"The object of this Association shall be to promote the welfare of the people of the State of Georgia, insofar as this may be done by the development of hospitals and dispensaries of the state, in number and in location; in service rendered to patients; in erection of buildings; in securing the best equipment and in promoting general efficiency of operation by securing co-operation and assistance in this work from all other organizations of similar purpose, and in all ways possible to

advance the interests of all medical service institutions."

"To this end this Association shall maintain such affiliation with the

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**The Georgia  
Hospital Association  
was formed after  
MAG's Committee on  
Hospitals was directed  
to appoint an  
organizational meeting  
in 1928. GHA was  
formed within the  
year.**

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American Hospital Association as shall, from time to time, be mutually desired, whereby it shall as the State of Georgia Section of the American Hospital Association, cooperate with it in promoting the common aims and purpose within this state."

Today, our Bylaws have combined the name and purpose into one Article. The purpose or object as it was initially referred, is now a mission. "The mission of the Georgia Hospital Association is to aggressively represent and serve as an advocate for its members and to assist its members in developing efficient and effective quality hospital and other health care services designed to meet the health care needs of the public."

Although some words have been changed, the initial thrust is the same. The main reason for the Georgia Hospital Association to exist is to assist its members in meeting the health care needs of others.

**T**his historical overview brings us to the second R, RENEWAL.

This is an appropriate time for each of us, both personally and as leaders in our respective institutions, to review and renew the commitment as stated in our bylaws to

develop efficient and effective quality hospital and other health care services designed to meet the health care needs of the public.

**D**uring the last several years, our hospitals have been restructured. We have looked indepth at the business we are in and, as a result, made significant changes in our organization structure. I believe that our hospitals today are more efficient, better managed, better equipped, and have developed more effective strategic plans than any time in our history. This has come about because each of us, as far as our individual institutions is concerned, has reflected on our institution's mission, has reviewed that mission which has resulted in appropriate reforms. This type of internal refocus, brings us to the third R, REFORM. Let's think about reform as far as the Georgia Hospital Association is concerned.

To reform, we first must have a form. Our present organization has served us well but, as we look toward the future, are changes needed? Time does not permit a full discussion of all possible actions we as an association should take. In fact, maybe our time can be spent most productively this morning by looking at the external environment which our member institutions face. Then we can address the reforms, if any, that are needed over the next several months.

Let's look at our mission one more time: "The mission of the Georgia Hospital Association is to aggressively represent and serve as an advocate for its members and to assist its members in developing efficient and effective quality hospital and other health care services designed to meet the health care needs of the public."

What does this advocacy and assistance really entail? From an advocacy perspective, let's look at a few of the public policy issues that must be addressed:

1. How do we control cost? Policies based on short run cost cutting are shortsighted. In many instances, they are more expensive in the long run. Are we providing unnecessary services? Are we provid-



ing services that are necessary but in an excessive manner? To control cost, do we limit the quality of service to everyone we serve? Cost is not a single issue separate all by itself, but rather is a part of every activity in which we are involved. This brings us to the second question.

2. How will needed health care services be provided the uninsured, the underinsured, the indigent, and the medically indigent? Who will pay for these groups and what is an acceptable minimum standard of care for them? Is the array of likely choices limited to mandating benefit coverage in small businesses, expanding Medicaid through changes in eligibility requirements, establishing state risk pools, and expanding direct financing to public institutions or are there other options? What is the appropriate role for the Georgia Hospital Association as far as these choices is concerned?

3. How do we address quality in a competitive environment? In the future, quality will become more and more important whether it is driven by the need to insure that quality does not suffer from cost containment or by the needs of providers, managed care organizations, or insurers trying to market service on quality lines, the focus on quality will intensify. What is our association's role as far as this critical issues is concerned? The availability of computer-generated data bases, the increased flow of information between provider and payers, and the increasingly competitive environment will intensify the need for an appropriate role by GHA.

4. How do we educate and train a sufficient number of health care professionals? What is the best way to work with other organizations who share this same concern? Do new types of care givers need to be developed? If so, who should be responsible for their education and supervision?

5. Our hospitals are becoming more and more capital intense. How do we improve our access to capital? How do we balance capital flow that is responsive to market opportunities with capital flow that is

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## **The main reason for the Georgia Hospital Association to exist is to assist its members in meeting the health care needs of others.**

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needed to increase access to the system?

6. Closely related to this is the encouragement to develop and use more effective technologies. Do changes need to be made in our state health planning rules so that appropriate technology adoption is not restricted, but at the same time not unnecessarily duplicated? How do we revise our Medicaid coverages to insure adequate access to new technologies for that covered population? What role should the Georgia Hospital Association have in expanding outcome-based research on new technologies? Do we have a role as an association to provide consumers with adequate information on technology and coverage policies so that they can make rational decisions?

7. Tort liability and escalating insurance premiums will continue to be a problem. How do we as an association address that issue?

8. Patients with AIDS continue to receive a lot of attention. In its publications regarding the treatment of patients with AIDS, the Georgia Hospital Association has been most helpful, but our activities should not stop here. Issues such as the broad societal choices about public health education, testing and reporting, and civil rights questions on housing, employment, and access to welfare and insurance are still before us. Difficult public policy decisions are ahead of us over who pays for care, where care will be provided, the role of the volunteer sector, and coping with the extreme pressures on providers, insurers, and payers in those institutions and localities where the number of AIDS patients is high.

9. Closely related is the overall subject of ethics. Ethics will be in

the public spotlight more and more in the days to come. With new technology available, ethical choices will become more difficult. How is the best way to work with our member institutions in addressing this issue?

**T**his list of advocacy concerns is not complete. It is only a start. It can help us, however, better focus on some of the critical factors facing the Georgia Hospital Association. Although we don't know all the answers, it is evident that GHA must continue to provide a forum where these difficult issues can be debated and industry-wide resolution developed.

What does our mission statement really mean as far as institutional member assistance is concerned? As we strive to develop an environment which has adequate access, we must be certain that we also have a system that has adequate payment. We must continue to work with the American Hospital Association and other national groups in our Save Medicare program. At the state level, we must step up our efforts as far as improving our Medicaid coverage is concerned, both from the standpoint of payment as well as from the standpoint of people served. The assistance that the Georgia Hospital Association renders its members, however, is also related to the efficiency of the membership in delivering health care services. We must continue to identify operating changes that increase efficiency and expand the study of the effectiveness of alternative treatment techniques and new procedures, devices, and equipment to enhance health delivery. Although most of the "fat" is out of the system, any remaining excesses must be identified and eliminated as expeditiously as possible. In other words, as the Georgia Hospital Association continues its efforts to do everything possible to make certain that we receive adequate payment for our services, we also must make certain that our services are adequate to meet the needs of the communities we serve.

**T**hese are interesting times in which we live; we face significant problems ahead. It is gratifying for us to realize that we do not face the future alone. The Georgia Hospital Association was established as a result of and with the strong support and cooperation of the Medical Association of Georgia. Among our first officers was the Secretary of the State Board of Examiners for Nurses. And our second president was the director of nurses at Grady Memorial Hospital. All of us must continue to work together. An anonymous curbstome philosopher once remarked that the main reason an organization loses its optimism is that its optics become misty. It may be wise for us

to remember the words of General George C. Marshall almost 42 years ago, in the spring of 1947 at a Harvard University commencement when he proposed that America aid those nations of Europe that had been devastated by the Second World War. In a few short paragraphs, he charted a course that eventually was followed by Congress to open the way for the great economic and political achievements throughout the Western World. Instead of using the rebirth of western Europe as a convenient way to fight an ideology, he listed the enemies as hunger, poverty, desperation, and chaos.

As we look to our future, it is important that we remember that

our enemies today are not the profit-making companies, Congressional or State politicians, the Health Care Financing Administration bureaucrats, the insurance companies, certainly not other hospitals and physicians, and no, not even the attorneys. Our enemies are still death, disease, disability, pain, and human suffering.

"Three score and more" has been a good theme for our 60th annual convention. The "three score" is history. What happens with the "more" is up to us. As I look up to our GHA leadership and look out to the leadership that is in this audience, I feel very confident that the "more" is in good hands, and I am most optimistic about our future. ■

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# On The Hill Again

U.S. Senator Wyche Fowler, Jr.

I AM PLEASED to be with you and have the opportunity to talk with you as we look ahead to a new Congress and a new presidency. The renewed energy that's in the air in Washington has reminded me how fortunate I feel to continue in a career of public service. It is hard for me to believe that I have served 2 years as your senator. That's hard to get used to, maybe because I got so used to reading my premature political epitaph 3 years ago.

But I feel even more fortunate as I stand here now, since if I had not won election to the Senate in 1986, I'd have to face this room full of physicians as a practicing attorney. You know the story of the engineer, the priest, and the attorney stranded on a desert isle, surrounded by sharks.

I can mention that to you because I was a lawyer and because I never sued a doctor. In fact, I never had a human client. My practice was confined to mammals, however, and did not comprise marine life in any form. Anyway, I'm glad to be with you here today as your senator.

There is a general air of optimism with a new administration coming in, especially one that is seeking consensus instead of confrontation. There is so far a spirit of bipartisanship and cooperation. I have pledged my efforts to work with the new president in every way I can for the common interests of

Georgians and Americans.

Despite this air of optimism, expectations are bridled by the size of the debt we are carrying over from the Reagan administration. We are ready for some new beginnings. But we all know the focus will remain the same: resolving this slumbering fiscal crisis. At the same time, we've got to try to go about our business of meeting crucial public needs.

As a member of the Senate Budget Committee and a new member of the Appropriations Committee, I am

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**Medicare spending is projected to go from \$86.7 billion in fiscal '89 to \$94.9 billion in fiscal '90. As recently as 1975, the total cost for Medicare was \$14 billion.**

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glad I am in the best position to represent Georgia on this most pressing issue facing our nation. I say this knowing I have many difficult decisions ahead of me.

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This article represents the speech Senator Fowler delivered to MAG's Leadership Conference in Atlanta last February. His address is United States Senate, 204 Russell Senate Office Building, Washington, D.C. 20510.

We've got a faltering Savings and Loan industry and decayed nuclear weapons facilities howling outside our door — ready to draw off billions of unbudgeted dollars. And I have just worked my way to the center of the storm. That is enough to stir apprehension in anyone. It may be that I just don't have better sense, but I am looking forward to these challenges.

Not the least of these is the challenge we face in providing and paying for the health care of our citizens in coming years.

Federal funding for health care in the last administration remained more or less stagnant, while health care costs have increased dramatically. Also, because of the demographics in our country, with so many of our citizens approaching old age, there will be greater demands on our health care system than ever before. Ironically, this burden has been created by the longer life expectancy of Americans due to advances in health care. And to extend the paradox, we are hitting a cost crunch in medicine because of these same advances. There are so many more conditions we are able to treat, using more sophisticated methods. But the miracle treatments and technologies are straining our capacity to pay for medical care — on the personal, institutional, and governmental levels.

The fiscal strain on federal health care programs, which is already severe, is going to become extraordinary as the number of Americans over 65 increases. According to the Congressional Budget Office, the costs of Medicare are going to rise rapidly unless there is further restructuring of the program. The CBO says the costs could double by 1994. Medicare spending is projected to go from \$86.7 billion in fiscal '89 to \$94.9 billion in fiscal '90. As recently as 1975, the total cost for Medicare was \$14 billion.

**N**one of this is news to you. Yet it has increased the concern aroused over the last few months whenever President-elect and now President Bush made any statement concerning federal spending for health care. Especially when the incoming president has mentioned health care specifically as a target for spending cuts. During the campaign, he threw out the idea of letting poor people buy into Medicaid, for valid humanitarian reasons. That idea needed life-support once cost estimates started circulating, especially since the only funding source would be cuts in other health entitlements. But Bush is expected to propose \$400 million in new Medicaid spending in 1990, to provide prenatal care and Medicaid buy-in opportunities for the working poor.

I suppose we could argue the relative advantages of different programs all day long, in more technical terms than most people are prepared to listen to. But what really concerns me is that very little of this discussion would really get to the heart of the issues we are facing across the whole spectrum of our population in health care.

I have travelled to 159 countries in this state, and everywhere I have been concerns about health care availability and affordability top the list. People don't know how they are going to cure their sick child. They don't know how they are going to care for their elderly parent. There is nothing as personal and close to home as medical care. It takes precedence over almost every other issue. And, frankly, I am hearing a

lot of worried people around the state.

As a nation, we are starting to entertain questions that were unthinkable 20 years ago. We never

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**Politicians always manage to have the last word, as you know, but it is only the medical community itself that can make a real claim to the confidence of the people in these matters.**

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used to wonder: can we afford better health care? Will our ability to pay for it diminish in the future? And there is a more nettling question: will all Americans benefit from advances in medicine or will the best treatments of the future be reserved for the wealthy? This may represent one of the severest tests yet of medical ethics. We have already had a brief glimpse of this with the demand for AZT among AIDS patients. These are difficult questions to answer, because it goes against our grain to even consider them. Yet the financial constraints are inescapable.

Under the Reagan administration I think we have had some important reverses in health care. We have had to be miserly in funding for teaching hospitals. That was a convenient place to go for deficit reduction, but may show up in bigger and more costly problems later on. The same is true of attempts to cut federal aid to nursing and other students in the health profession — at a time when there is a documented shortage of nurses in the country.

**T**he other area in which we have clearly regressed, for a variety of reasons that are not entirely the government's fault, is rural health. This has been a concern of mine as a member of the Senate Agriculture Committee and the Rural

Health Caucus, as one who has promoted efforts at rural development.

Access to health care in our major metropolitan centers remains good for those who can afford it. In the country, it's a different story. Our rural hospitals are closed down or endangered. In 1986, there were 10 Georgia counties with no physician at all, of any kind, and this number has increased. There has been an even more alarming decline in obstetric and other specialized services, which have all but vanished from the countryside.

And we have seen how the availability of health care affects every other dimension of society and the economy. Young families are not going to live where they cannot receive prenatal, delivery, and infant care. Companies are not going to relocate and bring jobs to places where there is no access to hospital care, where there are no doctors, and where indicators such as the rate of infant mortality show poor living conditions.

I think we need to hold the line on programs such as the National Health Services Corps, which has placed 95 doctors in rural Georgia — without who our deficiency would be even more severe. We are also going to have to look harder for resources and expertise outside the public sector to reverse these trends and ensure adequate health care for all our citizens.

**T**hat is not to say we have not made any progress recently in Washington. The best example is the expansion of Medicare to cover catastrophic health care. This was a revenue neutral solution, paid for through increased Medicare premiums that are tied to taxable income. In this case, there was an unusually strong consensus between Congress and the Administration. I think the solution was in the best American tradition of those with the most helping carry the freight for the less fortunate. But it is far too early to hold this out as a model. We still have to monitor the effectiveness of this program over time. And the increased premiums that will pay for the program



are just now going into effect. There will no doubt be a careful gauging of the reaction to those costs before we can draw any lessons from this legislation.

But in this particular case there was general agreement that the trade-offs would be worthwhile. This program is not free, by any means. But Medicare will now cover an entire year's hospital stay after payment of an annual deductible. Previously, only the first 60 days were completely covered, and partial coverage stopped after 150 days. For many long-term patients, this represented drop off into financial oblivion.

Another benefit is the Mikulski provision which states that the elderly no longer have to "spend down" to the last \$3,000 of their resources before qualifying for Medicaid. This virtually established a poverty requirement for our elderly faced with long-term, expensive health care.

I think this legislation may prove effective, but it does not come close to solving all the problems we face — in finances, and resources — where health care, and particularly nursing home care, for our elderly is concerned.

We have to resist the temptation to throw up our hands and say we can't solve these problems because we don't have the money. We don't have enough. But one thing that is not in short supply is information. One thing we can do is make better use of it. Perhaps the biggest realistic challenge and opportunity we face is managing information about health care: not only for doctors, but for patients, and patients as consumers.

We have greater opportunities than ever before, with the communications technology that now exists, to manage and transfer information on cases, causes, and cures.

Some initiatives are already underway, with publication of government standards for exposure to carcinogens in cosmetics and food. We can and should rely on better-informed patients, as well as doctors, to reduce major illness — as the surest way to cut health costs.

**I** have taken steps of my own in this vein, introducing legislation that seeks to inform farmers and consumers about dangerous chemicals in our food supply. I have attempted to restrict importation of tainted food products. I have a bill before the Congress now to encourage farmers, through information and incentives, to reduce the carcinogens applied to our crops and poisons that contaminate our groundwater, eventually finding their way into every part of the ecosystem.

I believe citizens have a right to protection that only the government, in conjunction with the latest medical research, can provide. We should all work together so that our citizens can make good health promotion an integral part of their daily lives, not just of their medical care.

Doctors will have to take the lead in setting these priorities and selling them in the public arena. Not everyone sets great store in the arguments we carry on in Washington, but private physicians do hold a position of trust. People don't really have choice. They have to trust and follow the advice of their own doctor. Their only alternative is to find and trust another doctor.

I think that more and more this personal trust will be called on as we face these issues and problems in the public arena. Politicians always manage to have the last word, as you know, but it is only the medical community itself that can make a real claim to the confidence of the people in these matters.

I am laying a lot of responsibility at the feet of physicians — over and above your already demanding practices, in the public domain: reducing the deficit, bringing down individual health care costs, promoting healthier agricultural, environmental practices, and consumer purchases.

**W**ith all these concerns in mind, I suppose I should return to the question of what we can expect in the next administration. President Bush has promised a kinder, gentler America. We should do our best to help him do it and hold him to it. We can have hopes

for a new administration, but we cannot expect too much. Because our success depends on so much more than any administration line. President Bush by himself cannot transform American health care. That will require the efforts of all dedicated professionals and community leaders.

We saw some demonstrations in the last administration of how that can be done. We saw it on the AIDS Commission, where a layman, Admiral Watkins, had the courage to oppose intransigent elements in the public sector and inject a degree of humanity into the fight against AIDS. It's a positive sign that the President has endorsed the commission's findings.

We saw the same thing from Surgeon General Koop, who fought hard for the citizen's right to objective information on health threats to the general population. He fought for the pure principle that the job of the doctor is to care for the patient, not to enforce moral judgments on him.

That is one thing I believe most strongly about health care, that some of these questions about when life begins and what lifestyles should be tolerated are really ethical questions; they are theological and medical questions. The answers cannot properly be legislated.

I agree with Koop, who fought for the essential idea that doctors, not politicians and ideologues, must be the leading force in our nation's health care system — in partnership with the government and the public.

On questions regarding individuals and their own health — and who they will turn to when they are hurt — I want to keep those questions to the greatest possible extent between the doctor and the patient.

You can take that as a compliment if you like, but it is really the most solemn obligation. If you realize that and guard that trust, then I think you will be surprised at how your influence will be felt not only on health care issues, but in all the other matters of human endeavor in which you are naturally interested as citizens and leaders in your community. ■

## *Medical Records of Minors — Procedures Regarding Disclosure*

*Kenneth I. Sokolov*

**P**HYSICIANS AND HOSPITALS in Georgia are frequently confronted with questions concerning the circumstances under which they may release the medical records of their minor patients. Such questions often include whether the minor patient may request to see his or her own medical records or whether such authority rests exclusively with the parents. Further, if the authority to review the records does rest with the parents, what happens if the parents are divorced? Finally, are the laws regarding disclosure of the minor's medical records affected by the nature of the treatment in question, specifically, if the treatment relates to venereal disease, abortion, or AIDS?

In this month's Legal Page, we address each of these questions and provide an overview of the law in Georgia with regard to the medical records of minors.

### **Overview of Georgia "Medical Records" Law**

Under Georgia law, records, "containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given," including progress notes, medication orders, and a discharge summary, must be maintained on each hospital patient. If the patient is a minor at the time of discharge, the law requires that the records be maintained until the patient's 27th birthday.<sup>1</sup>

The information contained in the medical records, including "the patient's state of health, his anatomical debilities, and the opinions, diagnoses, and tests of his doctors," is generally considered confidential, and certain communications contained in these records may also be subject to evidentiary privileges.<sup>2</sup> Nevertheless, the patient generally is entitled to a complete and current copy of that record, unless the physician reasonably determines that disclosure of the record to the patient will be detrimental to the patient, whereupon the records must be transferred to another physician at the patient's written request.<sup>3</sup>

### **Persons Entitled to Review the Medical Records of a Minor**

The age of legal majority in Georgia is 18, prior to which all persons are minors.<sup>4</sup> Under Georgia law, minors are held to be under the control of their parents, who are entitled to their services and to the proceeds of their labor.<sup>5</sup> Consistent with their legal duty to support their minor child, and upon submission of written authorization to the treating physician or hospital, parents are generally entitled to

receive all medical information concerning the treatment of their child.<sup>6</sup> Exceptions to this rule exist with regard to treatment provided by a psychiatrist and with respect to a hospital in which the patient has been or is being treated solely for mental illness. (Upon reaching 18, the age of majority in Georgia, the patient is authorized to review his or her records, to the exclusion of his or her parents.)<sup>7</sup>

**‘Parental rights, including the right to obtain a copy of a child's medical records, may be lost under a variety of circumstances.’**

Parental rights, including the right to obtain a copy of a child's medical records, may be lost under a variety of circumstances. For example, by engaging in a lawful marriage, a minor is automatically emancipated under Georgia law, thus entitling the minor to demand access to his own medical records. Similarly, the spouses of minor patients, even if themselves minors, are entitled to review the medical records of their spouses.<sup>8</sup>

This article was prepared at the request of the *Journal*. Mr. Sokolov is an associate in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., NE, Atlanta, GA 30326.



Parental rights may also be forfeited by a voluntary contract, pursuant to which the parental rights are released to a third party; by consent to the adoption of the child; by the failure to provide necessities for the child; or as a result of the abandonment or cruel treatment of the child.<sup>9</sup> Under each of these circumstances, the authority of the parent to demand access to the minor's medical records may be lost, and the physician or hospital responding to a written request for disclosure by one purporting to act as the parent of the minor would be well-advised in unusual or suspicious situations to ensure that parental

**‘Any physician or hospital providing a copy of the medical records or disclosing pertinent treatment information to the minor’s parents, upon written request, may not be held liable to the minor patient or to any other person on account of such disclosure.’**

authority has not been lost or terminated.

Any physician or hospital providing a copy of the medical records or disclosing pertinent treatment information to the minor's parents, upon written request, may not be held liable to the minor patient or to any other person on account of such disclosure.<sup>10</sup>

**Is It Right to Release the Minor’s Records if the Treatment Involves Venereal Disease, Abortion, or AIDS?**

The law regarding the disclosure of the medical records of a minor may vary, such as where the records reflect the treatment of venereal disease, the performance of an abortion, or AIDS. In cases involving the treatment of a minor for venereal disease,<sup>11</sup> the treating physician *may*, but is *not obligated* to, inform the spouse, parent, custodian, or guardian of any such minor as to the treatment given or needed. Moreover, the physician is empowered to give or to withhold from the spouse, parent, custodian or guardian information regarding treatment of the minor's venereal disease, *without* the consent of the minor patient and even over the express refusal of the minor patient.<sup>12</sup> However, in all cases involving the treatment of venereal disease, whether of minors or adults, the physician is required to make a

**‘The law regarding the disclosure of the medical records of a minor may vary, such as where the records reflect the treatment of venereal disease, the performance of an abortion, or AIDS.’**

report regarding such treatment to the Georgia Department of Human Resources. In addition, all laboratories conducting tests for venereal disease are required to report all positive test results to the Department, including the name, address, race, age, and sex of the patient.<sup>13</sup>

The issue of the physician's duty to disclose to the parents information regarding performance of abortion services on an unemancipated minor has yet to be resolved in Georgia. While the Georgia Legislature enacted the Parental Notification Statute, effective July 1, 1987,<sup>14</sup> which purports to bar the physician from performing an abortion on an unemancipated minor without the written consent of one of the minor's parents, the constitutionality of this statute and of similar statutes throughout the United States has been called

into question by several courts.<sup>15</sup> Final resolution of this issue must await the decision of the United States Supreme Court in *Hodgson v. Minnesota*,<sup>16</sup> which the Court is expected to deliver sometime in 1990. If the Supreme Court upholds the authority of the states to require parental approval for the performance of an abortion upon an unemancipated minor, the physician's duties regarding abortion procedures upon a minor in Georgia will be changed substantially in accordance with the Parental Notification Statute. For present purposes, however, it is clear that the physician performing an abortion must prepare and deliver a report concerning such abortion to the Department of Human Resources within 10 days of the procedure.<sup>17</sup>

With respect to the treatment of AIDS, the Georgia Legislature recently enacted a comprehensive statute dealing with the disclosure of information revealing the identities of persons diagnosed as having this condition.<sup>18</sup> While a complete description of this statute is beyond the scope of this article, several provisions are relevant to the present discussion. First, the physician or hospital is specifically authorized under the statute to disclose to the parents the fact that their minor child has been diagnosed with AIDS. In addition, the diagnosis may be disclosed to the minor's sexual partner, provided an attempt has been made to notify the patient that such disclosure is going to be made. If the sexual partner of the minor having AIDS is also a minor, disclosure may be made to that person's parents. The AIDS-related information may also be disclosed to any person or entity designated in writing by the minor's parents. Finally, the parents may order their child to

submit to an AIDS test, without the minor's consent.

### **Effect of Divorce on the Attending Physician's Duty to Disclose the Minor's Medical Records to the Parents**

Frequently, the physician or hospital treating a minor will be confronted with a request for the patient's medical records by one of the minor's divorced parents. This, in turn, raises the question of whether the right of the parents to review the medical records of their child extends, in the case of

**‘In the situation involving divorced parents, it is prudent for the physician or hospital to consult with the custodial parent after receiving a request by the noncustodial parent to review the minor's medical records.’**

divorce, only to the parent awarded custody of the child pursuant to the terms of a formal divorce decree or to the custodial and the noncustodial parent as well. While the Georgia courts have not had occasion to rule on this precise issue, it is generally considered that the custodial parent has complete authority with regard to decisions affecting the health and well-being of the child. It would thus appear prudent for the physician or

hospital to consult with the custodial parent after receiving a request by the noncustodial parent to review the minor's medical records.

Oftentimes the divorced parents will be able to reach an agreement among themselves as to the noncustodial parent's right to review the medical records of the minor patient, and every attempt should be made to promote such an agreement between the parties. Furthermore, the divorce decree between the parents may contain a specific provision regarding the noncustodial parent's right to review their child's medical records.

In the final analysis, however, if the custodial parent refuses to authorize the disclosure of the child's medical records to a noncustodial parent lacking specific authority under the divorce decree to review such records, the provider would appear warranted in refusing to honor the noncustodial parent's request. The physician or hospital in this instance would be advised to refrain from disclosing the records until presented with an appropriate agreement between the parties, a subpoena, or other legally enforceable document. Because of the evolving nature of the law in this area, however, it is recommended that the physician or hospital contact an attorney in difficult cases that are not amenable to resolution on the basis of the suggestions and recommendations outlined in this article.

### **Conclusion**

As a general rule, the parents of an unemancipated minor have the authority to review the medical records pertaining to the treatment of the minor patient.

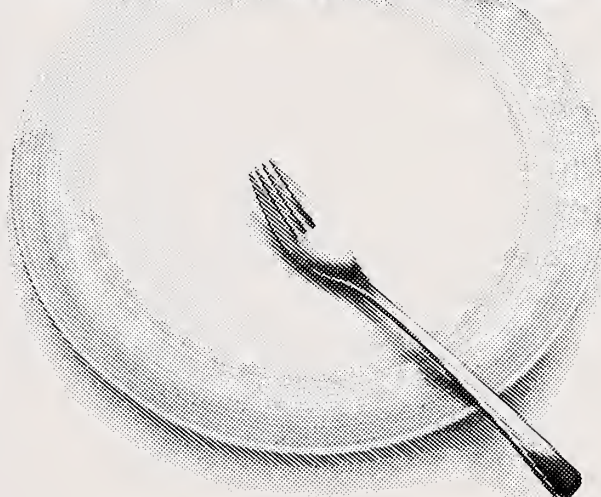


However, the provider's duty with regard to the disclosure of the minor's medical records depends in part on the nature of the treatment involved. In particular, additional/different reporting requirements are imposed on the provider in cases involving treatment of the minor for venereal disease, abortion, and AIDS. In cases involving a request for medical records by the noncustodial parent, every effort should be made to secure the consent of the custodial parent or to establish the noncustodial parent's authority, under the terms of the pertinent divorce decree, to review the subject medical record.

#### Notes

1. Rule 290-5-6-.11(a),(h), Rules of Department of Human Resources, Public Health.
2. *Dennis v. Adcock*, 138 Ga.App. 425, 226 S.E.2d 292 (1976); *Bazemore v. Savannah Hospital*, 171 Ga. 257, 155 S.E. 194 (1930).
3. O.C.G.A. §31-33-2.
4. O.C.G.A. §39-1-1.
5. O.C.G.A. §19-7-1.
6. O.C.G.A. §19-7-2; O.C.G.A. §24-9-40.
7. *Id.*
8. O.C.G.A. §19-7-1(5); *Irby v. State*, 196 S.E. 101 (1933); *Street v. Cobb County School District*, 520 F.Supp. 1170 (N.D.Ga. 1981); *McGregor v. McGregor*, 237 Ga. 57, 226 S.E.2d 591 (1976).
9. O.C.G.A. §19-7-1.
10. O.C.G.A. §24-9-44.
11. O.C.G.A. §31-17-1. See also *Long v. Adams*, 175 Ga.App. 538, 333 S.E.2d 852 (1985) (Genital herpes is also a contagious venereal disease even though not included in the definition of venereal disease set forth at O.C.G.A. §31-17-1).
12. O.C.G.A. §31-17-7(b).
13. Rule 290-5-17-.02, Rules of Department of Human Resources, Public Health.
14. O.C.G.A. §15-11-110 et seq.
15. See, for example, *Planned Parenthood Association v. Harris*, 670 F.Supp. 971 (N.D. Ga. 1987).
16. 57 U.S.L.W. 3859.
17. Rule 290-5-32-.03, Rules of Department of Human Resources, Public Health.
18. O.C.G.A. §24-9-47.

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**MANUSCRIPTS** — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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# VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

**Contraindications:** VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions:** *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients:

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

#### Drug Interactions:

**Hypotension: Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of <sup>14</sup>C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**HYPERTENSION:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**HEART FAILURE:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypotension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest, pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

#### Clinical Laboratory Test Findings:

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration: Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily after the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19380.

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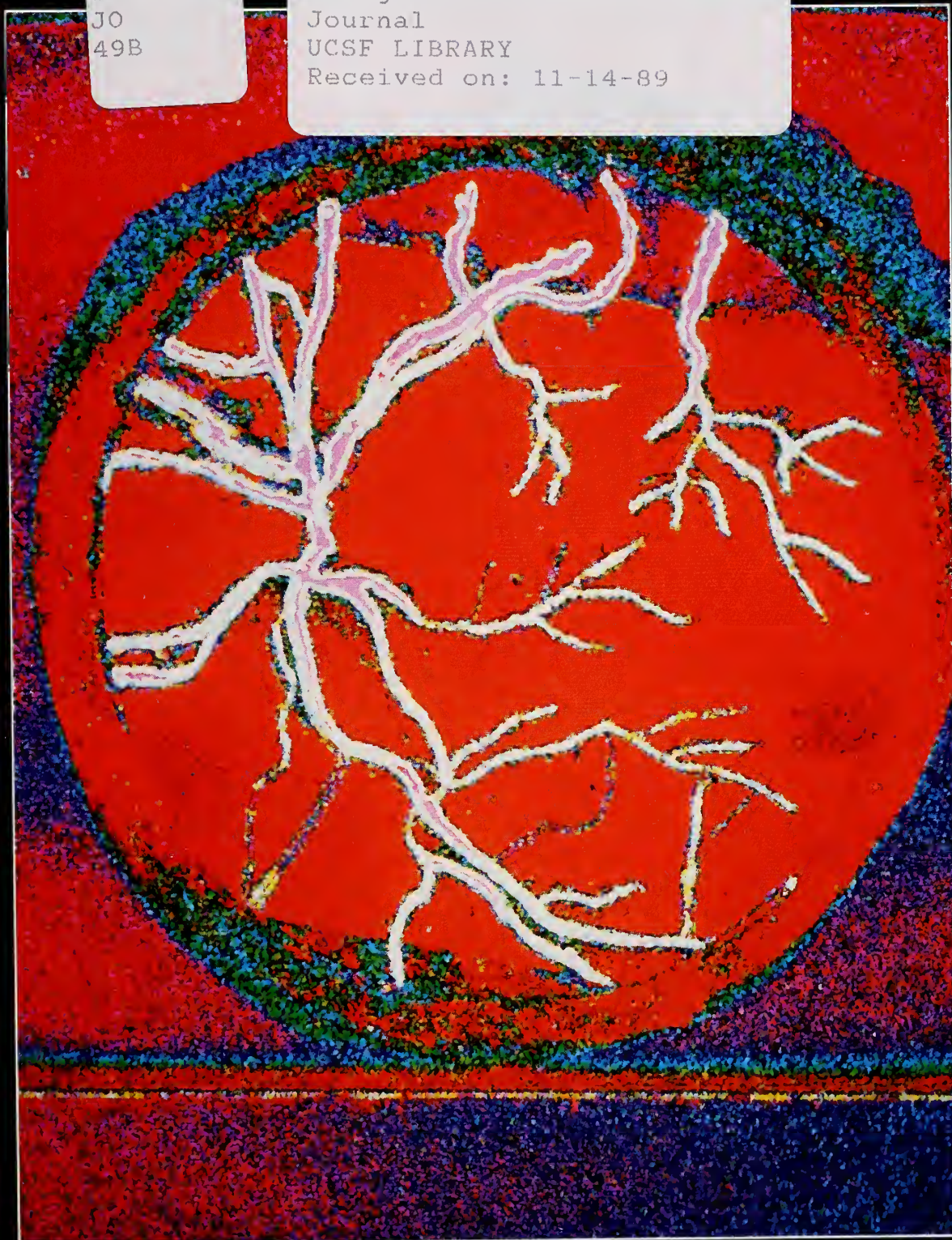


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**THE COVER**

The cover shows a computer-enhanced fluorescein angiogram of the retina. The delicately branching arterioles and venules which present such a striking pattern in this photo are also one of the tissues most susceptible to diabetic damage. Fluorescein angiography and other techniques permit early detection of abnormalities associated with diabetes and intervention before damage is severe.

Photograph by Howard Sochurek, of New York City.



# MRI UPDATE

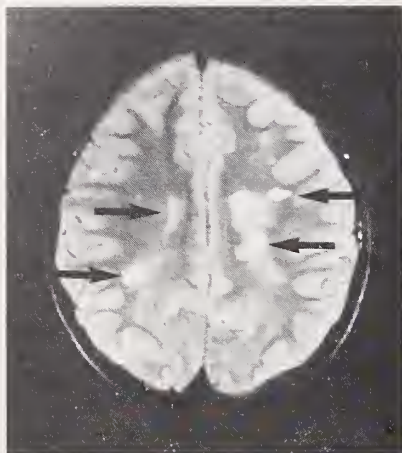


Figure 1

## CLINICAL INFORMATION:

Recently, there has been much discussion in the literature of the neurological symptoms caused by the spirochete *Borrelia burgdorferi*. The disease is transmitted by a tick bite and is associated with clinical symptoms of headaches, multiple arthralgias, and non-specific neurological symptoms. Given the appropriate clinical history, a diagnosis of Lyme disease can readily be confirmed by an MR scan.

**FINDINGS:** Figure 1 is a T2-weighted axial image through the brain. Abnormal focal areas of increased signal intensity can be identified within the centrum semiovale bilaterally (small arrows). These lesions are primarily located within the white matter but are of differing sizes. Figure 2 is also an axial image through the brain but at a level through the lateral ventricles. This section shows a

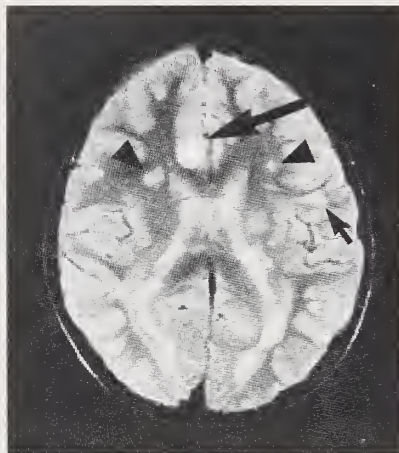


Figure 2

lesion located within the medial gray matter of the right frontal lobe anterior to the corpus callosum (large arrow). Additional areas of abnormal increased signal intensity can be identified adjacent to the occipital horns, in the gray-white matter interface of the left parietal operculum (small arrow), and in the deep white matter of the frontal lobes in the region of the anterior corona radiata (arrowheads). Figure 3 is through the posterior fossa as well as the lower frontal and temporal lobes. Abnormal areas of increased signal intensity are demonstrated in the left anterior pons (large arrow) in the anterior right temporal lobe (small arrow), in the right cerebellar peduncle (arrowhead), and in the medial right temporal lobe (curved arrow).

The MR images clearly demonstrate the predominantly white matter involvement, multifocal nature, and the absence of



Figure 3

mass effect associated with these lesions. In the absence of clinical history, the MR appearance would be most consistent with a demyelinating process such as multiple sclerosis. However, as this case presented in a nine year old male following exposure to ticks, the differential diagnosis becomes that of Lyme disease. The diagnosis was further confirmed by the findings of similar, although less extensive lesions, in the patient's sibling.

**COMMENT:** The patient in the case above had a CT scan prior to the MR study which was negative. This case clearly demonstrates the increased sensitivity of MR over CT in detection of white matter processes. However, the case also demonstrates the relative non-specificity of the findings. In this case, the clinical history was most important in determining the true etiology of the patient's findings.



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## *Catfish in a Mullet Barrel*

**L**AST WEEK in Savannah at the Georgia Medical Society office, there was a hearing to discuss the problem doctors throughout Georgia are having with Medicare Part B and its implementation by AEtna and its revised organization, HealthCare Compare. Attending this meeting were about 250 physicians from all over Georgia, two Congressmen, several administrators and office managers, representatives from HCFA, AEtna, and HealthCare Compare, attorneys from the AMA and MAG, and a Baltimore firm with a successful track record in dealing with HCFA and AEtna.

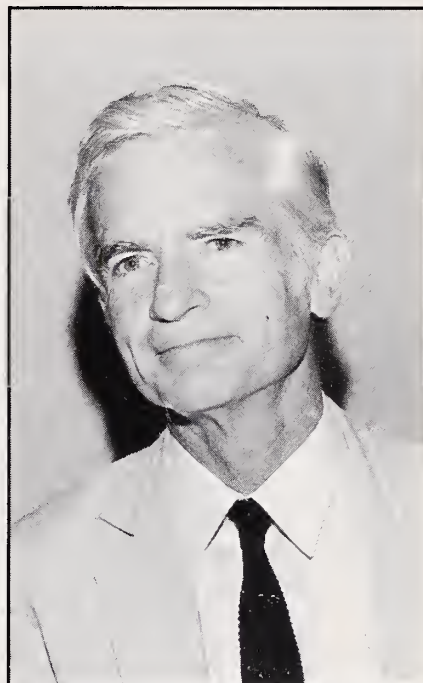
The Congressmen and bureaucrats listened as account after account of instances of arbitrary down-coding of claims, mistakes in processing, 6-month backlogs of appeals, and other examples of inefficiency — either by design or ineptness — were related. Doctor after doctor related how the situation is affecting their ability to practice medicine and how some are having to quit practice or are facing that threat.

After these problems were so vividly related, Barbara Cagel, HCFA's Vice President, expressed shock that such apparent problems exist. The AEtna

response was defensive but tentative. Our Congressmen appeared sympathetic to our problems. This meeting may not wind up changing anything, but then again, it might.

**P**residing at the meeting, and the person who worked hardest to bring it about, was Dr. Frank Carlton, president of the Georgia Medical Society. (The Savannah area medical society retains that name as it antedates the Medical Association of Georgia.) Frank is a man with a mission. That mission is to preserve the traditional and proper practice of medicine. In accomplishing this goal, Frank expresses a take charge personality that may sometimes be regarded as pushy or abrasive — in the eyes of bureaucrats, lawyers, fellow physicians, and even U.S. Congressmen.

I discussed this with my good friend Bob Quattlebaum, the chairman of the Board of Trustees of the Georgia Medical Society and Frank's former partner. Bob said, "Frank's a catfish in a mullet barrel." He then went on to describe how in olden times, before refrigeration, the fishermen at sea would carry fresh fish back to port in large barrels of sea



*Joe L. Nettles, M.D.*

water. To keep the mullet and other flat fish from getting sleepy and lying down on the bottom of the barrel and being crushed or suffocated, the fisherman would toss in a spring catfish to keep the fish agitated and moving and thus aerating the water and keeping the fish alive.

A tremendous amount of work has been expanded by many people to try and solve the problems we face within medicine. MAG staff, Dr. Joe Bailey, Dr. Tom Anderson, and many others are pushing this as our number one priority and have enlisted the aid of the Florida Medical Association and the AMA. We are meeting with HCFA in Baltimore soon to draft legislation which may enable us to succeed in solving this problem.

Frank Carlton is not going to let me or anyone else go to sleep on this job. We need this catfish in our mullet barrel — Keep up the good work, Frank. Ouch!!

## NEW MEMBERS

Brown, Reay H., Ophthalmology — MMA — (Active) 1327 Clifton Rd., NE, Atlanta 30322

Carter, Mary E., Pediatrics — Troup — (Active N2) 303 Smith St., La Grange 30240

Corbitt, Larry L., Anesthesiology — Georgia Medical — (Active) Ste. 3, 515 @ 63rd, Savannah 31405

Dailey, William J., Internal Medicine — Troup — (Active N2) 303 Smith St., La Grange 30240

Dave, Niranjana J., Internal Medicine/Cardiology — Cobb — (Active) 1791 Mulkey Rd., Ste. 101, Austell 30001

Davis, Alan D., Orthopaedic Surgery — MAA — (Active) 115 Oak Knoll Rd., Fayetteville 30214

Ebersbacher, Donald J., Internal Medicine — Carroll-Haralson — (Active) 612 North Ave., Villa Rica 30180

Fisher, Allan J., Obstetrics/Gynecology — MAA — (Resident) 5737 Longbow Dr., Stone Mountain 30087

Gaines, Oscar C., Emergency Medicine — Ware — (Active N2) 1616 Moss Creek Rd., Waycross 31501

Gaston, Gloria S., Internal Medicine — MAA — (Active N2) 730 Peachtree St., NE, Atlanta 30308

Glassman, Alan D., Pediatrics — Crawford W. Long — (Active N2) 1010 Prince Ave., Athens 30606

Grimsley, Edwin W., Internal Medicine — Decatur-Seminole — (Active N2) 1506 Evans St., Bainbridge 31717

Hicks, Winnie C., Family Practice — Wayne — (Active N1) Box 997, Jesup 31545

Jones, Allen W., Jr., Family Practice — Troup — (Active) 303 Smith St., La Grange 30240

Klug, Gerardo A., Obstetrics/Gynecology — Mitchell — (Active) 34 South Ellis St., Camilla 31730

Lorenzen, Paul C., Orthopaedics — Georgia Medical — (Active) 44 Medical Arts Center, Savannah 31499

McGowan, Diane L., Otolaryngology — Troup — (Active N2) 303 Smith St., La Grange 30240

McGowan, James P., Internal Medicine — Troup — (Active) 303 Smith St., La Grange 30240

Montgomery, William K., Obstetrics/Gynecology — Floyd-Polk-Chattooga — (Active N2) 1105 North Fifth Ave., Rome 30161

Morris, Jonathan B., Emergency Medicine — Cobb — (Active) 271 Shaded Oaks Lane, Marietta 30067

Pappas, Stephen G., Neurology — Glynn — (Active) 3216 Shrine Rd., Brunswick 31250

Powers, Danae M., Anesthesiology — MAA — (Active) 1364 Clifton Rd., NE, Atlanta 30322

Price, Gina G. — DeKalb — (Resident) 300 Blvd., NE, Atlanta 30312

Shihata, Fikry K., Anesthesiology — Whitfield-Murray — (Active) 123 Huntington Rd., Dalton 30720

Weems, Diane Z., Pediatrics — Georgia Medical — (Active) P.O. Box 1427, Savannah 31416-1257

## PERSONALS

### *Bibb CMS*

**William C. Acton, M.D.**, from Macon, was named recently as a fellow of the American College of Radiology (ACR), during ceremonies at the ACR annual meeting in Seattle, WA. Selected for his outstanding contributions to the field of radiology, Dr. Acton was named as one of 107 new fellows by the College's Board of Chancellors.

### *Georgia Medical Society*

**Robert F. Long, Jr., M.D.**, from Savannah, was named as a fellow of the American College of Radiology (ACR), at the ACR annual meeting in Seattle, WA. Fellowships in the College are awarded for significant scientific or clinical research in the field of radiology or significant contributions to its literature. Criteria for selection also include performance of outstanding service as a teacher of radiology, service to organized medicine, and an outstanding reputation among colleagues and the local community as a result of long-term superior service.



## *Clayton-Fayette CMS*

**Raju Vanapalli, M.D.**, an orthopedic surgeon in Atlanta, was elected recently as chief of staff at Henry General Hospital.

## *Medical Association of Atlanta*

**Naomi Parver Alazraki, M.D.**, Professor of Radiology, Co-Director of Emory University's Nuclear Medicine Programs, and Chief of Nuclear Medicine at the Veterans Administration Medical Center in Atlanta, has been elected president of The Society of Nuclear Medicine, which represents 12,000 physicians, scientists, and other professionals involved with the use of nuclear medicine techniques for the diagnosis and treatment of disease. Dr. Alazraki will take office in June 1990.

Before joining the Emory Medical Faculty in 1986, Dr. Alazraki was chief of the nuclear medicine service at the Veterans Administration Medical Center at Salt Lake City and professor of radiology at the University of Utah School of Medicine. Previously, she was chief of the nuclear medicine service at the VAMC in San Diego, where she held a faculty position at the University of California School of Medicine.

**Ray L. Watts, M.D.**, assistant professor in Emory's Department of Neurology, recently was named the winner of the 1989 George C. Cotzias Memorial Research Fellowship from the American Parkinson Disease Association (APDA). The fellowship was established in honor of the scientist who discovered the use of L-Dopa to help alleviate the symptoms of Parkinson Disease. It is given only once every 1 or 2

years to a young investigator by the APDA, which is the largest organization in North America that serves patients with Parkinson Disease.

## *Oconee Valley CMS*

At a special meeting of the Greene County Board of Health last July, **William H. Rhodes, Jr., M.D.**, a family practitioner from Union Point, was elected as the new Chairman of that county's Board of Health.

## DEATHS

**Edward Forrester, M.D.**, an orthopedic and arthroscopic surgeon on staff at Newton General Hospital and in private practice in the FNB Medical Building since 1986, died last August from amyotrophic lateral sclerosis (Lou Gehrig's disease). He was 55.

A native of Albany, Dr. Forrester was a former chief of surgery at Newton General Hospital. Prior to opening his practice in Covington, he had more than 17 years of medical experience in orthopedics with emphasis in spinal, trauma, and sports medicine.

A 1960 graduate of the Medical College of Georgia, Dr. Forrester completed his residency in general surgery at MCG and his orthopedic surgery residency at Grady Memorial Hospital.

**John J. Hyers, M.D.**, an anesthesiologist from Atlanta, died last August. He was 53.

Dr. Hyers had been on the staff of Piedmont Hospital in Atlanta since 1966. He was an Army veteran of the Vietnam War. He graduated from the University of Georgia and received his M.D. degree from the Medical College of Georgia.

**William P. Leonard, M.D.**, a retired surgeon, died last August at the age of 76.

Dr. Leonard had been in private practice as a general surgeon at the Doctors Building and Crawford W. Long Memorial Hospital for nearly 40 years. During World War II, he was an Army major assigned to the 38th Evacuation Hospital in Africa and Italy and was awarded the Bronze Star.

**Ronald Barry Prince, M.D.**, an internist from Covington, died last August following a bicycle accident while vacationing at Kiawah Island near Charleston. He was 37.

A native of Carroll County, Dr. Prince graduated cum laude from the University of Georgia with a degree in pharmacy in 1975. He received his degree in medicine from the Medical College of Georgia and completed his residency work in Youngstown, Ohio. He began his medical practice in Covington in 1982.

Dr. Prince was a past secretary-treasurer and vice chief of staff at Newton General Hospital and at the time of his death was chief of medicine there. ■

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## Of Blindness and Courage

*Something lost. Go and find it. Go  
and look behind the mountains.  
Something lost behind the  
mountains. Lost and waiting for  
you. Go!*

RUDYARD KIPLING

*To sing, to laugh, to dream,  
To walk in my own way and be  
alone,  
Free, with an eye to see things as  
they are,  
A voice that means manhood —  
to cock my hat  
Where I choose — At a word, a  
Yes, a No,  
To fight or write. To travel any  
road  
Under the sun, under the stars,  
nor doubt  
If fame or fortune lie beyond the  
bourne.  
Never to make a line I have not  
heard  
In my own heart; yet, with all  
modesty  
To say: "My soul, be satisfied  
with flowers,  
With fruit, with weeds even; but  
gather them  
In the one garden you may call  
your own."  
So, when I win some triumph, by  
some chance,  
Render no share to Caesar — in  
a word,  
I am too proud to be a parasite,  
And if my nature wants the germ  
that grows  
Towering to heaven like the  
mountain pine,  
Or like the oak, sheltering  
multitudes —  
I stand, not high it may be — but  
alone!*

Cyrano De Bergerac  
EDMOND ROSTAND

**I** WAS a third year, junior medical student when I realized, became rigidly convinced, that I was going blind. No doubt rested in my mind. My time was surely limited. The tiny, sometimes fuzzy, spots in my visual field not previously noted were now everywhere to be seen. Brightly lighted rooms, sunny days, pure white pages of paper brought them to prominence. I sat quietly in the medical library, obscure in the furthest cubicle from the others there, and switched my eyes restlessly across the pages of the book lending further credence to my panic. My heart raced. It had been a good life but too soon over.

The restless and distorting uncertainty gained ground on me to the end that I sought out the advice of the faculty ophthalmologist. He gazed with cool unconcern from behind the bright light, through the dilated pupil and on into the mysterious depth of the vitreous. "Humph," he groaned while maintaining his detachment, "they're just damned floaters. Go on back to Grady." "Damned floaters," I thought. "Hardly a proper diagnosis for a person going blind." After all, I was no fool. No fly-by-night adolescent. I was a junior medical student. I knew all one could want to know about the eye. About the anatomy and its physiology. About its rods and cones. Don't tell me those little spots won't get larger, coalesce, and cover my retina. "Floaters my ass, you say. I am going blind!"

**I** had known from childhood of blindness. My uncle, mother's brother, had suffered from craniostenosis. The father, he was a small town automobile dealer in the early days when Henry Ford toured the country visiting his dealers to be sure that they were the "right kind of folks," had taken him to Baltimore where Harvey Cushing operated upon him. But the blindness persisted. He would sit by the radio as Franklin Delano Roosevelt gave those mesmerising speeches and then with near infallibility, repeat the speech to me. Charles Wilson taught me about blindness. Taught me also that disabilities can with effort become assets and that dullness of some senses can sharpen others. He *saw* poorly but he *heard* and retained with an amazing degree of accuracy.

He was right, of course, the ophthalmologist. The scotomata floated their benign and casual way through the years providing diversion from seeing unsavory things too clearly and fading way as a catalyst to panic. And then I met Joyce, for such I will call her here.

"She has gallstones," the endocrinologist said when he asked for the consultation. "They should be removed. She is a juvenile diabetic controlled with insulin. Her kidneys are affected but at present functional without dialysis. She is almost blind from retinopathy. You will find her a pleasant and brave young lady." And so it was that I found her. Only 21 years of age and married to an attentive and loving young

man. A young child at home smiled from the picture frame on the bedside table. They were just back from Baltimore where a Johns Hopkins ophthalmologist had for the second time operated in a desperate effort to preserve vision. She groped in her darkened world to shake my hand. She laughed softly. "Let's do the operation tomorrow. I have things to do at home." We agreed on the plan, and I left the two of them looking out through my scotomata and my tears. Her calm and confident acceptance of so devastating an illness, the raw courage which she possessed allowing her to live her life to the fullest, left little room for anything save profound admiration.

**Y**ou will find in this issue of your *Journal* a number of articles on diabetes. Read them carefully. One need not be an endocrinologist nor an internist to have a need for knowledge of this disease process for it touches us all, be we "cognitive" or "procedural." It challenges us with its subtlety and its diversity. It teaches us about courage on the part of patients. One can only surmise of the self-reliance, the self-discipline necessary in the teenager told of a sudden that a disease process has arisen possessing the capacity to attack so many areas of the otherwise healthy body, the mastery of which will require a lifelong attention to details of conduct and living foreign to the carefree existence of most of us. Surely we will at length find the answer if not to prevention, then hopefully to reasonable and effective control.

It seems so long since 1922 when Banting and Best, in the *Canadian Medical Association Journal*, described the use of

pancreatic extract for the control of diabetes mellitus. We have come from those days through the development of modified insulin, the introduction of protein-purification procedures, the production of human insulin by recombinant DNA technology to the recent development of genetically engineered insulin analogues. We find ourselves now continuing the search for the solution through a myriad of answers including the transplantation of both whole organ pancreas and Islet cells to the placement of internally monitored insulin pumps. Somewhere in the distance lies the answer. The illusive and tantalizing solution. Beckoning and coaxing us both clinician and investigator alike to continue the search. The secret lies hidden. "Something lost. Go and find it."

## QUOTES

*Throw out opium, which the Creator himself seems to prescribe, for we often see the scarlet poppy growing in the cornfields, as if it were foreseen that wherever there is hunger to be fed there must also be pain to be soothed; throw out a few specifics which our art did not discover, and is hardly needed to apply; throw out wine, which is a food, and the vapors which produce the miracle of anesthesia, and I firmly believe that if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all for the better for mankind — and all the worse for the fishes.*  
O. W. HOLMES  
*Address to the Massachusetts Medical Society, Boston, May 30, 1860*

*If a man's character is to be abused, say what you will, there's nobody like a relation to do the business.*

WILLIAM MAKEPEACE THACKERAY

*There are several ways to apportion the family income, all of them unsatisfactory.*

ROBERT BENCHLEY

*Take a dose of medicine once, and in all probability you will be obliged to take an additional hundred afterward.*

NAPOLEON I

*To Barry E. O'Meara at St. Helena, Sept. 26, 1817*

*Be gracious to all men, but choose the best to be your friends.*

ISOCRATES

*Fidelity bought with money is overcome by money.*

SENECA

*Love affairs have always greatly interested me, but I do not greatly care for them in books or moving pictures. In a love affair I wish to be the hero, with no audience present.*

E. W. HOWE: *Sinner Sermons*, 1926

*While doubt stands still, confidence can erect a skyscraper.*

GEORGE LORIMER

*Time is the best medicine.*

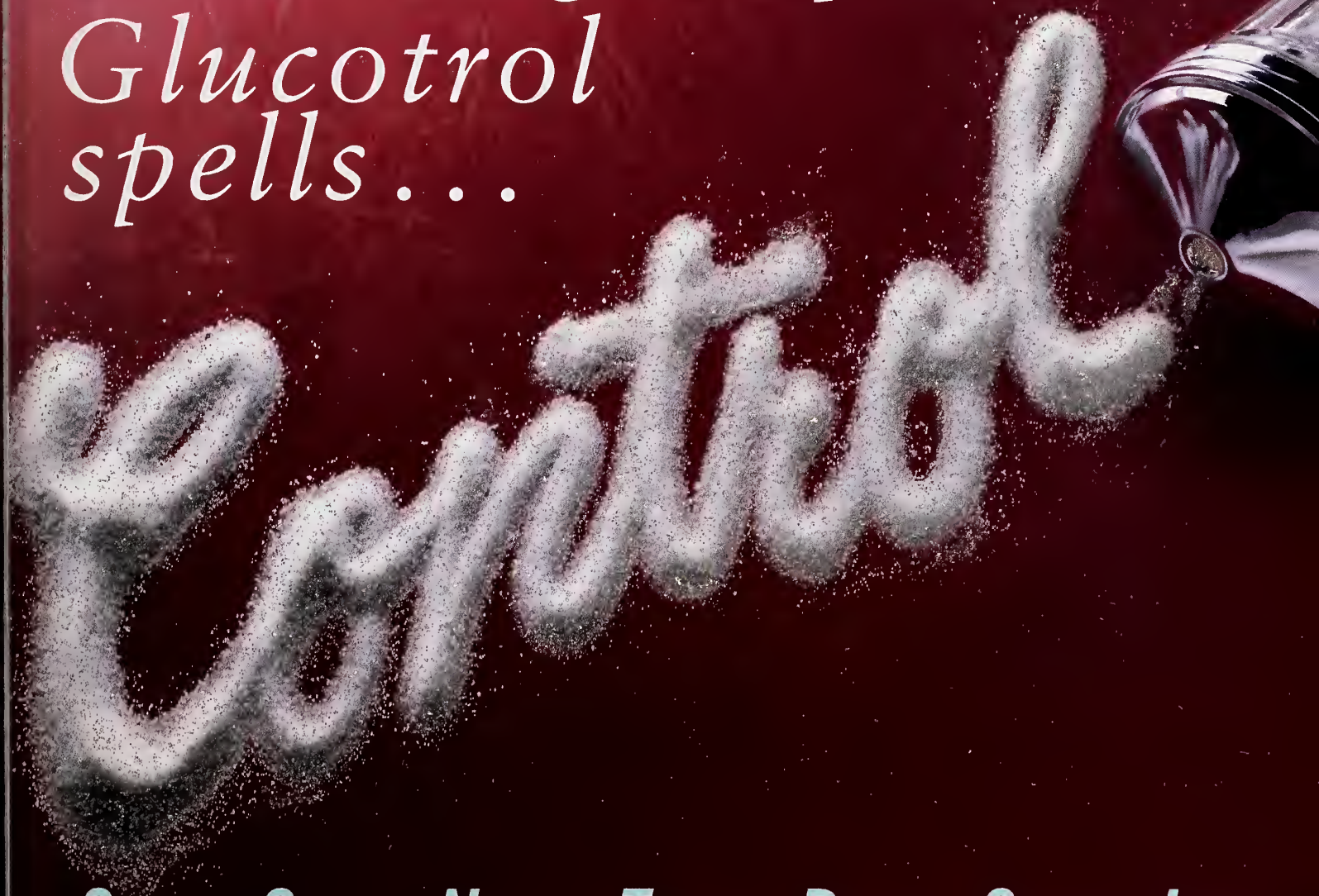
OVID: *Remedia amoris*, c. 10

*Be considerate of others. Be a good teamworker. Commend more and condemn less. Be a propelling force, not a brake.*

B.C. FORBES



*As fast as  
blood sugar spills,  
Glucotrol  
spells...*



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brand of  
endocri-  
nologists<sup>1</sup>

**O**nce-  
daily  
dosing


**N**ear-  
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insulin  
response  
to meals<sup>2</sup>

**T**olerated  
well by  
elderly  
patients<sup>\*3</sup>

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*Please see brief summary  
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*When diet alone fails in non-insulin-dependent diabetes mellitus*



# The reasons to prescribe Glucotrol can pile up fast

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#### References:

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#### GLUCOTROL® (glipizide) Tablets

##### Brief Summary of Prescribing Information

**INDICATIONS AND USAGE:** GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory.

**CONTRAINDICATIONS:** GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin.

**SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY:** The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy. Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

**PRECAUTIONS: Renal and Hepatic Disease:** The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia may be prolonged in such patients should it occur.

**Hypoglycemia:** All sulfonylureas are capable of producing severe hypoglycemia. Proper patient selection, dosage, and instructions are important to avoid hypoglycemia. Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs. Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs. Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used.

**Loss of Control of Blood Glucose:** A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery. It may then be necessary to discontinue GLUCOTROL and administer insulin.

**Laboratory Tests:** Blood and urine glucose should be monitored periodically. Measurement of glycosylated hemoglobin may be useful.

**Information for Patients:** Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose. The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members. Primary and secondary failure should also be explained.

**Drug Interactions:** The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta-adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation. Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid. A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported. Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity. Bacterial and *in vivo* mutagenicity

tests were uniformly negative. Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility.

**Pregnancy:** Pregnancy Category C. GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide. The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL. In studies in rats and rabbits no teratogenic effects were found. There are no adequate and well-controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible.

**Nonteratogenic Effects:** Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery. This has been reported more frequently with the use of agents with prolonged half-lives. GLUCOTROL should be discontinued at least one month before the expected delivery date.

**Nursing Mothers:** Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** In controlled studies, the frequency of serious adverse reactions reported was very low. Of 702 patients, 11.8% reported adverse reactions and in only 1.5% was GLUCOTROL discontinued.

**Hypoglycemia:** See PRECAUTIONS and OVERDOSAGE sections.

**Gastrointestinal:** Gastrointestinal disturbances, the most common, were reported with the following approximate incidence: nausea and diarrhea, one in 70; constipation and gastralgia, one in 100. They appear to be dose-related and may disappear on division or reduction of dosage. Cholestatic jaundice may occur rarely with sulfonylureas. GLUCOTROL should be discontinued if this occurs.

**Dermatologic:** Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria, pruritus, and eczema have been reported in about one in 70 patients. These may be transient and may disappear despite continued use of GLUCOTROL; if skin reactions persist, the drug should be discontinued. Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas.

**Hematologic:** Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas.

**Metabolic:** Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas. Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions.

**Endocrine Reactions:** Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas.

**Miscellaneous:** Dizziness, drowsiness, and headache have each been reported in about one in fifty patients treated with GLUCOTROL. They are usually transient and seldom require discontinuance of therapy.

**OVERDOSAGE:** Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia. If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL. Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery. Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease. Because of the extensive protein binding of GLUCOTROL, dialysis is unlikely to be of benefit.

**DOSEAGE AND ADMINISTRATION:** There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL; in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia.

**Initial Dose:** The recommended starting dose is 5 mg before breakfast. Geriatric patients or those with liver disease may be started on 2.5 mg. Dosage adjustments should ordinarily be in increments of 2.5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps.

**Maximum Dose:** The maximum recommended total daily dose is 40 mg.

**Maintenance:** Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing. Total daily doses above 15 mg should ordinarily be divided.

**HOW SUPPLIED:** GLUCOTROL is available as white, dye-free, scored, diamond-shaped tablets imprinted as follows: 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100; 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-66) Bottles of 100.

**CAUTION:** Federal law prohibits dispensing without prescription.

More detailed professional information available on request.

**ROERIG** **Pfizer** A division of Pfizer Pharmaceuticals  
New York, New York 10017



Dear Editor:

May I add to the article, "The Health and Economic Burden of Cigarette Smoking in Georgia in 1986?" I have never smoked in all my life, and I'm thankful for it.

As a retired pediatrician, I am still concerned about our youth. It is up to our parents to acquaint their pre-teenage school children of the dangers and risks of cigarette smoking. Education should be directed to them in the form of an adult education course for parents entitled "Family Living."

Sincerely,  
Henry Gall M.D.  
Cairo

Dear Editor:

For the first time, I learned in your magazine from the article by Dr. Van Buren ["One Internist's View of the RBRVS," September, 1989, JMAG, p. 611], about the inequity in payment and reimbursement to internists and found out about the old wound that they have recognized for a long time. For many years I set my own fees for all of my patients and still set my fees with the exception of those changes dictated by government programs. I had been under the impression that internists did the same, including fees for laboratory studies and x-rays made in their offices.

I see the word "cognitive" used. Somehow or other I get the impression that some folks feel that they are the only ones who can think. The word has an arrogance to it and not too subtle inference that this process

belongs only to certain ones of us and that cognition is not involved in the diagnosis and judgements made insofar as doing or following up surgery.

Although one cannot use one factor as a guideline for evaluation of responsibility involved, I would like to note that my malpractice insurance runs about six times that of the average primary care physician.

It can also be noted that when one uses an operating room, one is subject to a tremendous amount of expenditure of time which is not efficient. Being available for surgery, frequently having delays due to circumstances beyond the surgeon's control, the frequent cancelling of office patients, or delaying their being seen are built in hazards of the surgeon's trade which occur to a greater extent than in most primary care practices.

One should also consider ancillary income from laboratory and x-ray studies done in internist's offices.

The Harvard Resource Base RVS was mainly based on the survey of a relatively small sample of physicians who were asked to estimate time and intensity for a small number of services, a very subjective approach. In addition, there are a number of essential issues that have not been addressed at all by that study which are both complex and require careful consideration. It may be that the author of the recent article doesn't look on the "social statement" saying loudly and clearly that the services of the internal medicine specialty have been downgraded, diminished,

and treated with disrespect, as being devious but it so appears to me.

I value primary care physicians greatly, and I particularly appreciate the worth of internists when they are treating my ill patients. However, I don't understand the aggrieved, hurt attitude assumed by those determined to make an extra buck, even if it has to come from someone else's pocket.

Yours truly,  
P.K. Dixon, Jr., MD  
General Surgeon

## QUOTES

*There is more simplicity in the man who eats caviar on impulse than in the man who eats grapes on principle.*

G. K. CHESTERTON

*To be a good critic demands more brains and judgment than most men possess.*

JOSH BILLINGS

*Ridicule is the first and last argument of a fool.*

CHARLES SIMMONS

*Medicine may be regarded generally as the knowledge of the loves and desires of the body, and how to satisfy them or not.*  
PLATO: Symposium, c. 360 B.C.

*No one is useless in this world who lightens the burden of it to anyone else.*

CHARLES DICKENS

## NOVEMBER

### 5-8 — *Peachtree City: Group Leadership Conference.*

Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-10 — *Atlanta: Magnetic Resonance Imaging.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

9-11 — *Atlanta: Georgia Academy of Family Physicians.* AMA Category 1 Credit & AAFP prescribed. Contact Camille Day, GAFF, 3760 LaVista Rd., #100, Tucker 30084. PH: 404/321-7445 or 800/392-3841.

10-12 — *Atlanta: Gastroenterology for Primary Care Physicians.* Category 1 Credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

11 — *Atlanta: Anticonvulsants in Psychiatry: Update 1989.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

15-18 — *Kiawah Island, SC: Organ and Tissue Procurement and Transplantation — Advance Concepts.* Sponsored by the Medical College of Georgia and the South Carolina Organ Procurement Agency, Inc. Category 1 Credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

16 — *New Orleans, LA: Advances in the Diagnosis and Treatment of Cardiovascular Diseases.* Category 1 Credit. Contact Office of CME, Emory

Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

17-19 — *Atlanta: MAG Scientific Assembly.* Contact MAG, Dept. of Education, 938 Peachtree St., Atlanta 30309. PH: 404/876-7535 or 800/282-0224.

17-20 — *Peachtree City: 26th Annual Psychiatric Institute on Group Behavior and Group Leadership.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19 — *Atlanta: Gearing Up For Retirement.* Category 1 Credit. Contact S. Hill, American Medical Association, Dept. of Practice Management, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/645-4958.

## DECEMBER

2-3 — *Atlanta: Regional Anesthesia: Surgery, Obstetrics, and Pain.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

4-8 — *Atlanta: Magnetic Resonance Imaging.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

6-8 — *Atlanta: Nuclear Medicine Update: Infection, Renal, Cardiac, Brain & Lung Imaging, with Emphasis on SPECT.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

7-10 — *Atlanta: Workshops in Clinical Hypnosis.* Category 1

credit. Contact P. Schoefield, American Society of Clinical Hypnosis — Education and Research Foundation, 2250 E. Devon Ave., Suite 336, Des Plaines, IL 60018. PH: 312/297-3317.

8 — *Atlanta: Current Concepts in Glaucoma Management.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

9 — *Atlanta: Depression in Primary Care.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

14 — *Atlanta: Update: Infectious Diseases and Clinical Microbiology.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

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## FEBRUARY 1990

2-3 — *Atlanta: Annual Emory-Grady Postgraduate Ophthalmology Conference.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10 — *Atlanta: Ethical Decision Making in Medicine.* Category 1 Credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



## Georgians Rate Importance of Health Care in New Statewide Survey

**T**he Georgia Hospital Association has completed a survey of Georgians to find out their attitudes toward hospitals and their level of understanding of hospital issues.

Results of the survey show that more than 85% of Georgians believe everyone has the right to receive medical treatment regardless of the ability to pay. And, to cover the cost of that treatment, more money is needed from the state budget, said three quarters of the respondents. Georgians like the idea of obtaining part of that funding by requiring every county to contribute to the health care cost of its own residents who are poor. A large majority of Georgians — 81% — favor an increased alcohol tax as a means of paying for health care for Georgia's poor; close behind, more than 75% favor a state lottery to provide the funding.

But don't turn to hospital patients for the extra money, they say. A total of 82% did not want to see a tax on hospital patients as a source of health care funding.

As to who should receive first priority in health care funding, Georgians cited children as the group most deserving of additional funding. The second priority was funding for the elderly.

GHA also found a lot of confusion among the general public about how health care is currently funded. More than half think the state pays 80% or more of hospital expenses for Medicaid patients, whereas payments

actually cover much less. According to the hospital association, Medicaid coverage in 1987 amounted to only 64% of hospital charges. And on the Medicare side, coverage this year is projected to fall to 69% of hospitals' charges for treating those patients. In fact, the association says, Medicaid and Medicare payment shortfalls, coupled with little or no coverage for treating indigent patients, is one of the most pressing problems facing Georgia's hospitals.

Overall, Georgia's hospitals received a good report card from the survey respondents. Two thirds said they were satisfied with the care their local hospitals provide; three fourths said medical technology has become more available in Georgia over the past 5 years; and an overwhelming majority — 95% — said that hospitals and health care availability are important to their communities' well being.

## Hospitals Launch Letter-Writing Campaign to the White House

**H**ospitals in Georgia have joined the American Hospital Association's ongoing Medicare advocacy campaign, which now focuses on an appeal to the Bush administration to provide adequate Medicare funding in the fiscal year 1991 budget.

The campaign, which will take place in October and November, is designed to flood the White House with letters from hospital administrators, trustees, medical staff, auxiliaries, and employees

asking for a fair budget allotment for Medicare.

The program, dubbed "Promise to Protect Medicare," is the third phase of a national effort to save Medicare funding from further cuts, and it is the hospital industry's first effort to influence the budget at the beginning of the budget cycle. The Georgia Hospital Association has passed a resolution calling for statewide support of the campaign.

## Washington Cast a Jaundiced Eye at Catastrophic Coverage

**B**owing to widespread criticism of the catastrophic coverage act, the Senate Finance committee has begun closed-door sessions to determine how to amend the errors of the act, short of repealing the new program entirely.

Primary concerns are which benefits to keep and what reductions can be made in the supplemental premium that Medicare beneficiaries would have to pay. The Finance Committee reported that it was giving serious consideration to reducing or even eliminating coverage for drugs, skilled nursing care, and physician services. Cutbacks in those areas, would, in turn, reduce the supplemental premium.

Even with the revisions, however, some Washington observers predict that the Senate will repeal the law, and the Bush administration has even stated that it will not stand in the way of repeal. And a member of the Ways and Means Committee has further predicted that the House will kill the program.

# **MAG Launches PHYSICIANS CARE PROGRAM for Elderly Poor**

Senior Citizens and their problems continued to be a major concern of MAG. In an effort to meet the needs of our older patients, the MAG Board of Directors on October 1 approved a voluntary medical care program. Developed by the MAG Senior Citizens Advocacy Committee, the program is being called Physicians Care.

By now, many of you will have received information on the program, but just to recap briefly:

In this program, we are asking our members to sign on by agreeing to see eligible recipients at least one time. You will be asked to evaluate an acute condition and, with the patient, determine the extent of ongoing care to be provided.

MAG will determine patient eligibility and refer to volunteer physicians. To be eligible, the beneficiary must be 65 or over with an annual income at 150 percent of the federal poverty level of \$8,950 (1 person) or \$13,425 (couple).

You may be asking why you should participate,

since all of you already donate your services to indigent patients. Without a mechanism to assure access to physician care and to document the volume of participants, we have no effective means to respond to charges that the elderly are not getting medical care because they cannot afford it.

Please complete the inserted participation form and watch for more details from MAG.

We think you should participate:

- To assure access to physician services for the elderly poor, both Medicare-eligible beneficiaries and the uninsured.
- To document that physicians are already providing care to the most vulnerable elderly and are willing to do more.
- To establish a forum providing physician-oriented information to your patients, their families, our legislators, and others.



# PHYSICIANS CARE

## Physician Participation Agreement

**THIS INFORMATION IS PERSONAL AND CONFIDENTIAL**

I will participate in the following components of PHYSICIANS CARE.

I will see an eligible patient at least one time for an evaluation of an acute condition and, with the patient, mutually determine the extent of my services necessary for ongoing care for the following categories: (PLEASE CHECK ALL THAT APPLY)

- ☐ Category 1 — Patients 65 years of age or older with Medicare Coverage. I will accept Medicare approved amount for these services.
- ☐ Category 2 — Patients 65 years of age or older with no insurance.
- ☐ Category 3 — My own patients and those referred through normal referral patterns who meet one of the above criteria.
- ☐ Referrals may be made to me through this program.
- ☐ Do not place my name on a referral list.
- ☐ I must limit new patients to \_\_\_\_\_(number), per \_\_\_\_\_ year \_\_\_\_\_ quarter  
\_\_\_\_\_ month

\_\_\_\_\_  
Signature

Please print or type information below.

\_\_\_\_\_  
Name Telephone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Specialty

Please return to: Medical Association of Georgia  
938 Peachtree Street, NE  
Atlanta, Georgia 30309

# From BYNUM'S Scrapbook . . .

The sayings:

"An apple a day keeps the doctor away"  
Or its English version:

"Eat an apple going to bed,  
Make the doctor beg his bread."

are supposed to be based upon the myths that have appeared in every age and in every country.

Aphrodite's apple of discord is a far off echo from Eve's apple of sin and death, for legend, poetry, and painting are alike satisfied that it was an apple which grew on the Tree Of Knowledge of good and evil. In the Scandinavian saga, Indun keeps a box of apples, whereof the gods, "when they feel the approach of age, have only to taste and forthwith they become young again." In the Grecian myth, the dragon guards the sacred apples of The Hesperides, as in the Scriptures, the serpent watches over the apple in the Garden of Eden. In many a Norse story, the golden bird seeks the golden apples of the King's Garden.

It is, however, in the Arabian Tales that the apple becomes a healing fruit, and it is supposed from this have come the rhymes mentioned.

A bit over a generation ago a little apologue went the rounds of the American press, which summed up the valuable properties of the common apple:

"Do you know what you are eating?" said the doctor to the girl.

"An apple of course."

"You are eating" said the doctor, "albumen, sugar, gum, malic acid, galic acid, fibre, water, and phosphorus."

"I hope those things are good. They sound alarming!" said the girl.

"Nothing could be better. You ate, I observed, rather too much meat for dinner. The malic acid of apples neutralizes the excess of chalky matter caused by too much meat, and thereby helps to keep you young. Apples are good for your complexion; their acids help drive out the noxious matters which cause skin eruptions. They are good for your brain, which these same noxious matters, if retained, render sluggish. Moreover, the acids of the apple diminish the acidity of the stomach that comes with some forms of indigestion. The phosphorus, of which apples contain a larger per cent than any other fruit or vegetable, renews the essential matter of the brain and spinal column! Oh! The ancients were not wrong when they esteemed the apple the food of the gods — the magic renewal of youth to which the gods resorted when they felt themselves growing old and feeble. . . . I think I'll have an apple!" concluded the doctor.

*Richard Bynum Weeks, M.D.  
Retired Surgeon  
St. Simons Island, Georgia*



## *Diabetes Mellitus: Good Management Can Make a Difference*

*Suzanne S. P. Gebhart, M.D.*

**T**HERE ARE approximately 250,000 individuals in the State of Georgia with diabetes mellitus. About half of these individuals are not aware that they have the disease. Our present understanding of and management tools for this disease permit much to be done to improve the overall survival and outlook for such patients. This requires an enormous commitment of time and resources, not only by health professionals caring for diabetics but also by the diabetics themselves. If an attempt is to be made to maintain near physiologic glucose control, persons with diabetes must become experts in understanding the interplay of diet, exercise, stress, and insulin in daily glycemia. They must be comfortable adjusting their insulin, exercise, and diet to match their daily requirements, and they must recognize how to treat both hypo- and hyperglycemia effectively. This is asking a great deal of diabetic patients, but in exchange, they

gain a greater understanding of diabetics and take command of their diabetes management. Clearly, diabetic education becomes not only a desirable adjunct to medical management but also a necessary requirement.

The outlook on diabetic complications has been much more sanguine with the advent of early means of detection and intervention. We are now able to detect many complications at a point where they are reversible. Aggressive management of hypertension and glucose elevation appears to reduce the urinary excretion of minute quantities of albumin ( $< 200$  mg/24 hr), improve retinal blood flow, and improve nerve conduction. Advances in laser therapy for retinopathy have markedly decreased the risk of blindness in more advanced eye disease. Tight glycemic control during pregnancy has reduced maternal and infant morbidity and mortality to approximate that of the normal population.

**W**hile much can be done in diabetes management, it requires extensive commitment of health professionals and health dollars. This expenditure is to a large extent recouped with reduction in hospitalization and morbidity associated with

***‘Education of the diabetic patient becomes not only a desirable adjunct to medical management but also a necessary requirement.’***

diabetes. A remaining challenge is to ensure that these options are available to all persons with diabetes, regardless of income.

The Georgia Department of Human Resources, the U.S. Centers for Disease Control, and many volunteer groups committed to diabetes, such as the American Diabetes Association, the Juvenile Diabetes Foundation, and the Lions Club, have contributed substantially to promoting the importance of early detection of diabetes and of its complications. It is our hope that through the efforts of these and other volunteer groups, through the state Public Health Department, and through volunteer efforts by health professionals themselves, all individuals in the State of Georgia can benefit from these advances.

Dr. Gebhart is Assistant Professor of Medicine (Endocrinology and Metabolism) at Emory University and Director of the Diabetes Unit, Emory Clinic, 1365 Clifton Rd., Atlanta, GA 30322. She has served as Guest Editor of this special issue of the *Journal*.

***‘The outlook on diabetic complications has been much more sanguine with the advent of early means of detection and intervention. We are now able to detect many complications at a point where they are reversible.’***

We would like to acknowledge the contributions and support of the following individuals who served as reviewers of the articles in this special issue of the *Journal*:

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# Current Perspectives on the Prevalence and Pathogenesis of Diabetes Mellitus

Suzanne S. P. Gebhart, M.D.

## Introduction

**D**IABETES MELLITUS is a heterogeneous disorder characterized by hyperglycemia secondary to a relative or absolute lack of insulin.

It is estimated that there are approximately 10 million Americans with diabetes mellitus. It is found in 8% of the population over the age of 65 years. The terminology, classification, and diagnostic criteria for diabetes were standardized in 1979 as a result of an international workshop sponsored by the National Diabetes Data Group of the National Institutes of Health. Recommended standards, terminology, and diagnostic criteria are listed below.

## Classification

Diabetes mellitus is classified as follows:

1. Insulin-dependent diabetes mellitus (Type I), previously called juvenile diabetes or ketosis-prone diabetes.
2. Non-insulin dependent diabetes mellitus (Type II), formerly known as adult onset diabetes mellitus.

---

**While goals for glucose control must be individualized, it is often possible to emulate safely the natural pattern of insulin secretion and thus maintain blood glucose within a more physiologic range.**

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3. Diabetes secondary to other causes. This group includes diabetes post pancreatectomy, diabetes secondary to Cushing's syndrome, acromegaly, or other primary disorders.

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Dr. Gebhart is Assistant Professor of Medicine (Endocrinology and Metabolism) at Emory University and Director of the Diabetes Unit, Emory Clinic, 1365 Clifton Rd., Atlanta, GA 30322.

4. Impaired glucose tolerance: glucose levels higher than normal but not sufficiently high for the diagnosis of diabetes.
5. Gestational diabetes: diabetes associated with pregnancy but with return to normal glucose tolerance after delivery.
6. Statistical risk classes: Individuals who do not currently have diabetes but based on epidemiologic and research data are at high risk for diabetes. These include individuals who had a previous abnormality of glucose tolerance but are now normal and individuals who have a potential abnormality for glucose tolerance either because of a strong family history or because of the presence of circulating antibodies.

## Diagnostic Criteria

The criteria for the diagnosis of diabetes mellitus in non-pregnant adults are shown in Table 1. An oral glucose tolerance test is required only if fasting glucose levels are below diagnostic range.

**TABLE 1 — Diagnostic Criteria for Diabetes Mellitus**

**Non-pregnant Adults**

1. Random plasma glucose  $> 200$  mg/dl and classic signs and symptoms
2. Fasting plasma glucose  $\geq 140$  mg/dl on at least two occasions
3. 75 gm 2 hour oral glucose tolerance test  
     Plasma glucose  $< 140$  mg/dl fasting  
     Plasma glucose  $\leq 200$  mg/dl at 2 hour and at one intervening time point

**Impaired Glucose Tolerance**

- 75 g. 2 hour oral glucose tolerance test
- 1 hour  $\geq$  to 190 mg/dl
  - 2 hour plasma glucose between 140 and 200 mg/dl with an intervening plasma glucose  $\geq 200$  mg/dl

**Gestational diabetes**

- 100 gm oral glucose tolerance test
- 1 hour fasting plasma glucose  $\geq 105$  mg/dl
  - 1 hour  $\geq 190$  mg/dl
  - 2 hours  $\geq 165$  mg/dl
  - 3 hours  $\geq 145$  mg/dl.

**Diabetes mellitus in children**

1. Random plasma glucose  $> 200$  mg/dl & classic symptoms
2. Fasting glucose  $\geq 140$  mg/dl and an abnormal oral glucose tolerance test, 1.75 mg/kg IBW on more than one occasion. (Abnormal defined as: plasma glucose  $\geq 200$  mg/dl at 2 hour and at one intervening time point.)

**Pathogenesis of Insulin-Dependent Diabetes Mellitus**

It is possible to separate diabetes into two distinct groups related to etiology. Insulin-dependent diabetes (Type I) is associated with autoimmunity directed against the pancreas. Anti-islet cell antibodies are found early in the course of the disease, detectable in up to 85% of diabetic children within the first few weeks of diagnosis and declining in titer over the next 2-5 years. Cell mediated autoimmunity is abnormal as well. Diabetic lymphocytes exhibit cytotoxicity toward the insulin-producing beta cells and show inhibited migration on exposure to pancreatic antigens.

The genetic defect leading to altered autoimmunity is unclear. Certain alleles of the HLA system are associated with Type I diabetes. HLA DR3 and DR4 are associated with a four-fold risk of Type I diabetes. The presence of the heterozygote DR3/DR4 increases the risk of Type I diabetes by ten-fold, suggesting that the effect of these al-

leles involves independent mechanisms.

Investigation to further characterize DR4 & 3 subgroups in terms of susceptibility to insulin-dependent-diabetes mellitus has identified DR4 subgroup DQBw8 as conferring increased risk of insulin-dependent-diabetes mellitus and, in Caucasians, the presence of aspartic acid in the 57 position of DQB appears to be protective. Concordance of Type I diabetes in identical twins is only 50%, however, so non-genetic mechanisms also contribute to the development of this disorder. Current theory as to the etiology of Type I diabetes proposes the existence of a genetic defect which is activated by an environmental insult, perhaps a virus or a toxin, leading to ongoing destruction of the islet cells over ensuing months to years. By the time hyperglycemia develops, much of the islet destruction has already occurred. Current clinical investigations are studying the possibility of early detection and immunosuppression to halt islet cell destruction.

**Pathogenesis of Non-Insulin-Dependent Diabetes Mellitus**

Non-insulin-dependent diabetes mellitus (Type II), while generally occurring in older patients, has also been diagnosed in teenagers and young adults. This is a strongly familial disorder. Concordance among identical twins is approximately 90%, but there is no association with the HLA system. No genetic markers have been found. Environmental factors such as obesity, stress, and poor physical conditioning appear to be important.

Although insulin deficiency is a central feature of diabetes mellitus, many patients with non-insulin-dependent diabetes have normal or elevated basal insulin levels suggesting that the insulin secreted is less effective than normal in lowering glucose, an observation that has been termed "insulin resistance." In addition to insulin resistance, there is impaired insulin release in response to stimulation. When glucose is given intravenously, insulin release is delayed compared to normal individuals.

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**Many patients with non-insulin-dependent diabetes have normal or elevated basal insulin levels suggesting that the insulin secreted is less effective than normal in lowering glucose, an observation that has been termed "insulin resistance."**

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This is one of the first detectable abnormalities of glucose tolerance, and it may occur before there is an elevation in plasma glucose. Both impaired insulin secretion and peripheral insulin resistance are important characteristics of non-in-



sulin-dependent diabetes. Whether insulin resistance leads to impairment in insulin secretion or results from it is unclear; however, several forms of therapy have been noted to improve insulin resistance. Fasting or marked dietary restriction has been shown to lower basal insulin levels and improve glucose tolerance. A similar response has also been shown by using insulin therapy or oral hypoglycemic agents to lower plasma glucose levels. Therefore, hyperglycemia itself may not only be a result but also a contributor to the pathophysiologic defect in this disease.

### Approach to Management of Diabetes Mellitus

Many questions about diabetes remain unanswered; however, our understanding of this disorder and the tools which we have to treat it have markedly improved. There is

mounting evidence that the complications of diabetes may be the result of chronic hyperglycemia. In the normal individual, glycemic excursions are kept within narrow limits by brisk, well-modulated increases in insulin superimposed on basal insulin secretion. While goals for glucose control must be individualized, it is often possible to emulate safely the natural pattern of insulin secretion and thus maintain blood glucose within a more physiologic range. Using information obtained from home capillary glucose monitoring and laboratory analysis of glycated hemoglobin or fructosamine values, the physician and patient must juggle the armamentarium of therapy: diet, exercise, insulin and/or sulfonylurea drugs to achieve the desired glycemic goal.

Patient education, always advantageous, is essential if patients are

to adjust their regimens on a daily basis. While it is hoped that improved glucose control will prevent diabetic complications, existent complications may stabilize or even resolve with early detection and intervention. Life expectancy for the average diabetic has progressively increased over the last 40 years. Careful diabetes management may produce a similar beneficial effect on the development of long-term complications.

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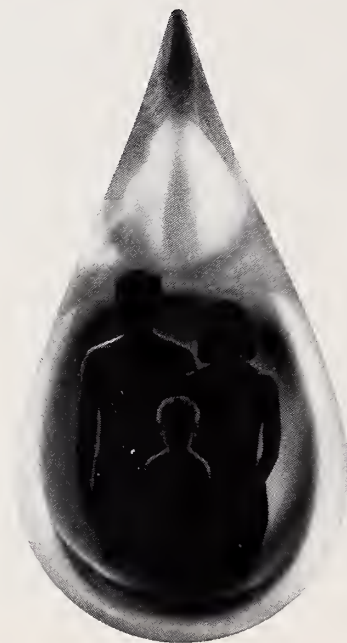
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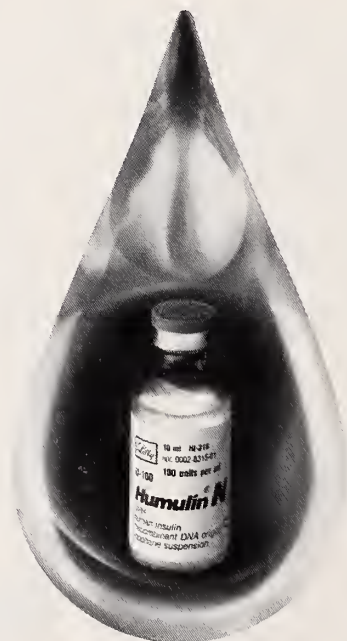
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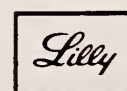


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# Critical Factors in the Surveillance and Management of Healthy Diabetic Patients

Edwin D. Bransome, Jr., M.D., Thomas A. Huff, M.D.

**T**HE DIAGNOSTIC CRITERIA for different diabetic syndromes are described in Table 1 of the article by Dr. Gebhart in this issue. The physician's role is to work with diabetic patients and their family members to work towards several objectives:

- Control of hyperglycemia
- Detection of acute complications so that they may be treated promptly
- Detection of chronic complications so that their progression may be prevented or slowed down by treatment

In Table 1, we have compiled some guidelines for the primary care of diabetes from recent publications of the American Diabetes Association and the Division of Diabetes Translation of the Centers for Disease Control.<sup>1-6</sup> While specific objectives of care have not been included because they require the judgment of the physician as to the needs of each patient, they merit discussion.

## Control of Hyperglycemia

Because of a deficiency of endogenous insulin, patients with insulin-dependent diabetes (Type I) not only have uncontrolled hyperglycemia but also develop ketoacidosis if they do not receive exogenous insulin. Without treatment this acute complication can result in coma and death within a few days. One objective of insulin replacement therapy for Type I patients is to eliminate ketosis and thus prevent ketoacidosis. A second objective is to eliminate the obvious consequences of uncontrolled hyperglycemia: polyuria, polyphagia, polydipsia, vaginitis or balanitis, recurrent infections, and visual blurring.

Conventional insulin therapy usually involves two daily subcutaneous injections of mixtures of short- and intermediate- or long-acting insulin. Biochemical objectives are:

1. Pre-meal blood glucose levels: 160-200 mg/dl
2. Intermittent positive urine glucose tests
3. Rare ketonuria
4. Glycohemoglobin 10-11% (HbA<sub>1c</sub> 8-9%)<sup>2</sup>

Another test providing an index of glycemic control, serum fructosamine, has recently become commercially available.<sup>7</sup> It is useful for monitoring changes over 2-3 weeks vs 2-3 months for glycosylated hemoglobin.

**I**n the late 1970s circumstantial evidence began to accumulate suggesting that achieving near normoglycemia could prevent the chronic complications of Type I diabetes: retinopathy, nephropathy, and neuropathy. Intensive insulin therapy is necessary to achieve this goal. Such therapy requires frequent self-monitoring of blood glucose, considerable patient educa-

Drs. Bransome and Huff are Professors of Medicine and members of the Section of Metabolic and Endocrine Disease at the Medical College of Georgia. Send reprint requests to Dr. Bransome, Department of Medicine, Medical College of Georgia, Augusta, GA 30910-3115

TABLE 1. Guidelines for Care of Patients with Diabetes Mellitus

### *I. Initial Visit*

#### *History*

Diagnostic Symptoms and Laboratory Studies

Weight History

Diet & Exercise History

Education and Treatment

Previous and Current

Hypoglycemia

Acute Complications:

DKA, Hyperosmolar Coma

Infection History

Foot, Skin, Dental, Genitourinary

Chronic Complications

Eye, Kidney, Nerve, Sexual Function

Feet, Peripheral Vascular, Cerebrovascular

Medications

Risk Factors for Atherosclerosis

Psychosocial and Economic Factors

Family History

Diabetes, Hypertension,

Other Endocrine Disorders

Gestational History

#### *Physical Exam*

Height and Weight

Blood Pressure (lying and standing)

Foot Exam

Ophthalmoscopic Exam

Thyroid

Cardiac Exam, with palpation and auscultation of pulses

Exam of Injection Sites, and General Skin Exam

Liver Size and texture

Neurological exam

Dental and Periodontal Exam

Children:

Initiation of Growth and Maturation Chart  
for Height, Weight, Sexual Maturation

#### *Laboratory Evaluation*

Fasting Plasma Glucose

Estimates of Chronic Hyperglycemia

Glycosylated Hemoglobin, Serum Fructosamine

Lipid Profile

Triglyceride

Cholesterol Total, LDL, HDL

Urinalysis

Culture if abnormal microscopic exam

Renal Function Studies

Serum Creatinine, Creatinine Clearance

Quantitative Urinary Proteins

Microalbuminuria (Timed Collection)

24 hour Urinary Protein

#### *Management Plan*

Statement of Goals

Medications

Dietary/Exercise Prescription

Timing of Meals and Exercise

Distribution of Caloric Intake

Patient and Family Education

Monitoring

Detection of Hypoglycemia

Self-Monitoring of Blood Glucose

Urinary Ketones

Foot Surveillance

Ophthalmology Referral

Diabetes of >5 years duration, or age >30

Establish Follow-up Schedules

Physician, Dietician, Nurse Educator

Sick-Day Strategies

### *II. Continuing Care*

#### *Interim History*

Patterns of Glycemic Dyscontrol

Hypoglycemia

Timing, Frequency, Severity

Hyperglycemia

Timing, Regularity, Degree

Records of Home Glucose Self-Monitoring

Patient's Adjustments of Medication Dosage

Adherence To Regimen

Symptoms of Complications

Old

New

Psychosocial Status

Other Medical Illnesses

Current Medications

#### *Physical Exam*

Annual: Full Exam

Interim:

Weight (And Height, for children)

Blood Pressure

Foot Exam

Fundoscopic Exam

Areas Indicated by Interim History

Children:

Chart Growth and Maturation:

Height, Weight, Sexual Maturation

#### *Laboratory:*

Annual:

Lipid Profile

Renal Studies

Urinalysis

After 5 Years of Diabetes, or after Puberty:

Microalbuminuria (if available) or Protein

Interval:

Glycosylated Hemoglobin and/or Serum Fructosamine:

Twice a Year in all patients

Four times a year in patients taking insulin, and in  
patients with poor control

#### *Review of Management Plan*

Weight Control

Exercise Program

Degree of Glycemic and Lipid Control

Hypoglycemia

Blood Pressure Control

Patterns of Self-Care and Adherence to Regimen

Assessment of Knowledge and Self-Management Skills

Assessment of Complications

### *III. Intercurrent Illnesses*

More Frequent Monitoring of Urinary Ketones

More Frequent Self-Blood Glucose Monitoring

Insulin Supplementation

Temporary Initiation of Insulin (in Type II Diabetes)

Sick Day Diet:

Replacement of carbohydrate portion of diet with measured,  
slow, continuous intake of glucose-containing fluids that  
patient can tolerate

Hospitalization for Intravenous Fluid Therapy

When Oral Intake is Compromised

(especially in Type 1 Diabetes)



TABLE 1. *Continued***IV. Special Problems**

**Diabetic Ketoacidosis and Hyperosmolar Coma**  
Direct physician control of the case is necessary

**Hypoglycemia**

This is the critical factor limiting the level of glycemic control that can be achieved. Frequent, severe, or unrecognized hypoglycemia requires revision of treatment goals.

**Pregnancy**

Excellent glycemic control from conception required to prevent fetal malformation, and throughout pregnancy to prevent maternal and fetal complications. Full training in self-monitoring of blood glucose, and organization of obstetrical support systems is necessary prior to pregnancy.

**Hypertension**

Aggressive treatment to normal blood pressure to reduce severity of retinal and renal microangiopathy.

**Retinopathy**

Annual exams by an Ophthalmologist  
Treatment of complicated patients by a retinal specialist familiar with the management of people with diabetes

**Neuropathy**

Monitoring for Early Sensory and Motor Changes  
Monitoring for Autonomic Dysfunction  
Consultation with Appropriate Specialists as Needed

**Nephropathy****Determination of Renal Function**

Annually in adults, or after 5 years of diabetes  
2-3 times a year if proteinuric, or if serum creatinine is elevated

**Hypertension, Smoking Control****Early Detection and Treatment of Infections**

Referral to Nephrologist upon Development of Early Renal Failure (Serum Creatinine >2.0 mg/dl.)

**Cardiovascular Disease****Monitor Risk Factors****Detection of Claudication****Detection of Angina or Anginal Equivalents****Foot Care****Examination at Every Visit****Repeated Education on Care of Insensitive Feet****Referral to Podiatrist or other medical professionals**

experienced in the management of diabetes for care of mechanical foot problems, calluses, protection of ulcers

**Children and Adolescents**

Should be managed in consultation with a physician who has expertise in treating children with diabetes.

## Conventional insulin therapy usually involves two daily subcutaneous injections of mixtures of short- and intermediate- or long-acting insulin.

tion and motivation, and insulin administration either with multiple daily injections or constant subcutaneous infusion. The biochemical goals of intensive insulin therapy are:<sup>2</sup>

1. Pre-meal blood glucose levels: 70-120 mg/dl
2. Post-meal blood glucose levels: <180mg/dl
3. Essentially no glucosuria or positive urine ketones

4. Glycohemoglobin: 7-9% (HbA<sub>1c</sub> 6.0-7%)<sup>2</sup>

The question of whether insulin therapy in patients with Type I diabetes can prevent chronic complications is currently being examined in a multicenter NIH-sponsored clinical study, the Diabetes Control and Complications Trial which will end in 1993.

If the patient is pregnant, the objectives of control of glycemia are different:

1. Pre-meal blood glucose levels: 60-105 mg/dl
2. Post-meal blood glucose levels <120 mg/dl
3. Glycohemoglobin: 5.5-7.0% (HbA<sub>1c</sub> 5.5-6.5%)

**C**ontrol of hyperglycemia in non-insulin-dependent diabetics (Type II) can sometimes be achieved by conforming to a diet (usually an ADA diet) designed to

minimize postprandial hyperglycemia. In obese patients with Type II disease, weight loss alone may be effective through decreasing insulin resistance. If diet is not effective, the combination of diet and an oral hypoglycemic agent — a sulfonylurea or biguanide (metformin is not yet approved for marketing in the US) or diet and insulin — is

**Because the risk of macrovascular disease is substantially increased in anyone with diabetes or even impaired glucose tolerance, it is important to address other risk factors such as smoking and hyperlipoproteinemia.**

appropriate. Acceptable levels of plasma glucose are <140 mg/dl fasting and <200 mg/dl 2 hours post prandial. Control is considered poor if fasting plasma glucose is >200

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**Control of blood pressure is particularly important, because hypertension accelerates the development of neuropathy and retinopathy.**

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mg/dl and postprandial >235 mg/dl. Glycosylated hemoglobins of <8% are acceptable; levels >10% indicate poor control.<sup>3</sup>

### Chronic Complications

Management of the chronic complications of diabetes initially involves lessening other risk factors. Control of blood pressure is particularly important, because hypertension accelerates the development of nephropathy and retinopathy.

The guidelines included in Table 1 suggest schedules of surveillance of the patient so that the earliest signs of complications are promptly detected, e.g., background retinopathy, microalbuminuria, and insensitive feet. Referral to an appropriate specialist so that treatment can be initiated is equally as important regarding complications as management of hyperglycemia.

Because the risk of macrovascular disease is substantially increased in anyone with diabetes or even impaired glucose tolerance, it is important to address other risk factors such as smoking and hy-

perlipoproteinemia. Fasting plasma cholesterol should be <240 mg/dl and triglycerides >200 mg/dl.<sup>3</sup>

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# Community-based Diabetes Programs

Charles O. Barker, M.D., Max E. Stachura, M.D.

**I**N THE EARLY 1970s, the general physician community exhibited what might be called a laissez-faire attitude about the treatment of diabetes mellitus. A common perspective held that how one treated and followed the patient with diabetes did not matter because complications of the disease would inevitably develop 15 or 20 years after its onset. There seemed to be ample reasons to justify this attitude. Since the mid 70s, however, the environment in which health professionals deal with diabetes mellitus has undergone marked changes. The medical community has subsequently been and is re-evaluating its approach to this disease.

At least two major factors have contributed to this positive and dynamic process. First, there is mounting evidence that tight glucose control can prevent or delay many of the complications of diabetes mellitus. Second, technical advances (e.g., home glucose mon-

itoring, use of glycosylated hemoglobin, better insulins) have enabled physicians to adopt a more positive attitude toward follow-up patient visits while minimizing the need for hospitalization simply to establish better glucose control.

Concurrent with these changes, health professionals have realized that to achieve tight glucose control in their patients a team approach to care is necessary. This includes active participation by the patient, physician, nurse, dietitian, etc. (Table 1). For this to occur, ongoing and available education and management programs must be placed within the community.

In any community, the initiation of such programs can originate through lay individuals or groups. Sustained activities, however, will require the interest and commitment of an individual who will serve as authority figure, decision maker,

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**The American Diabetes Association maintains offices at the national and state levels that can be approached for resources, advice, and the benefit of experience from other communities.**

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and facilitator. Usually that individual will be a physician. Then, cooperative interaction between interested laity and health care professionals will invariably be necessary for the effort to grow. How the program starts, develops, and flourishes will vary with the resources available in each community.

**T**he American Diabetes Association (ADA) maintains offices at the national and state levels that can be approached for resources, advice, and the benefit of experience from other communities. The Public Health Department exists in all state districts. Cooperative Extension Service agents based in

**TABLE 1. Community-based Diabetes Program Ingredients**

**Health Professionals**

**Essential:**

Physician (M.D., D.O.)

- Primary diabetes care
- Specialist (i.e. ophthalmology, Ob/Gyn, pediatrics, ect.)

Registered nurse

Registered dietician

**Extremely Helpful:**

Pharmacist

Podiatrist

Psychologist

Social worker

County extension service agent

**Support Groups**

American Diabetes Association (local chapter)

Community Service Group(s) and Organizations(s)

Church Group(s) and Organization(s)

Liaison Committee (local, including laity and health professionals)

**People Qualities**

Community sense

Commitment

Positive attitude

Determination

Persistence

**Tasks**

Identify local needs

- Diabetes care
- Diabetes education

Advocacy

Individual and group involvement

Individual and group action

Visibility

Availability

**Ideal Goals**

Regular targeted and comprehensive diabetes education programs

- Oriented to the individual with diabetes and his/her family
- Oriented to health care professionals

Episodic and comprehensive diabetes care programs

- Available to all individuals and socioeconomic groups

every Georgia county offer health-related programs in weight management, good nutrition, and diabetes information. Local service groups (e.g., Lions, Kiwanis, and Rotary) can play important, active roles, especially in community education and fund raising. They must be made aware of the need for diabetes education and management programs. Once involved, the essential characteristics that these individuals and groups must exhibit are a selfless sense of community coupled with commitment, determination, and persistence. A positive attitude to help overcome occasional, but inevitable, setbacks is another invaluable asset.

Finally, although the effort may have originated with an individual, its continuing success will require the formation of a liaison group

comprised of laity and health professionals who have sufficient community respect to enable them to informally coordinate all these activities and serve as a clearing-house for information exchange. Usually, the most concerned and committed individuals will gravitate to this informal committee where problems as well as present and future needs will be discussed at regular meetings. They will also raise public awareness by arranging for speakers or events targeted to inform all segments of the community.

**T**he development of the diabetes programs in Valdosta provides an instructive example. Valdosta, a community of 50,000, delivers medical services to over 200,000 in the

area. In 1976, through the concurrent awareness of the need for better diabetes services among health professionals and laity, a local women's Quota Club formed a chapter of the Georgia ADA affiliate. Outside speakers were brought in to discuss control and the team approach to diabetes care, as well as to provide encouragement. Early activities sponsored by the Chapter included monthly public, patient, and professional educational programs.

With time, the need to develop an ongoing comprehensive patient education program was recognized by several concerned and committed health care professionals. A group of these local professionals were then sent to an existing program in another state to gain experience.



At that point, Valdosta experienced a stroke of good fortune. Georgia and the Valdosta area in particular were chosen to receive federal funds as a part of a nationwide diabetes control program. This grant facilitated growth but really only funded what the local community had already decided to do on a private, voluntary basis: develop and implement a comprehensive diabetes education program. The fact that the commitment was the critical element was attested to when, after 2 years, federal funding was lost. The activity continued through unpaid volunteer effort, existing local health resources, and private contributions.

As experience grew, the community became aware of a service gap — lack of adequate care for the working poor and the nonworking poor who were ineligible for Medicaid. To fill this gap, those already committed to Valdosta's comprehensive diabetes education program had to become true advo-

cates, successfully approaching state legislators for the needed funds. Valdosta now claims with pride that all persons with diabetes mellitus, regardless of socioeconomic station, can receive both ap-

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**Diabetes education and care programs must be ongoing, supportive, and responsive to changing needs. Their success requires local initiative and a determination to stay the course.**

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propriate diabetes education and outpatient care.

The Valdosta program is not standing still. It is continuing to evolve. Further, it is a story that can, and should, be repeated throughout Georgia. The need is clear. There are resources that can be tapped. Support from Georgia's academic medical centers is available. However, just as the health care teams success in caring for the individual with diabetes depends upon his/her commitment to use their support, the success of community-based comprehensive diabetes education and care programs depends on the commitment of key individuals in the community.

Diabetes mellitus is a chronic condition that requires continuous management; there is no cure. Diabetes education and care programs must therefore be ongoing, supportive, and responsive to changing needs. Their success requires local initiative and a determination to stay the course.

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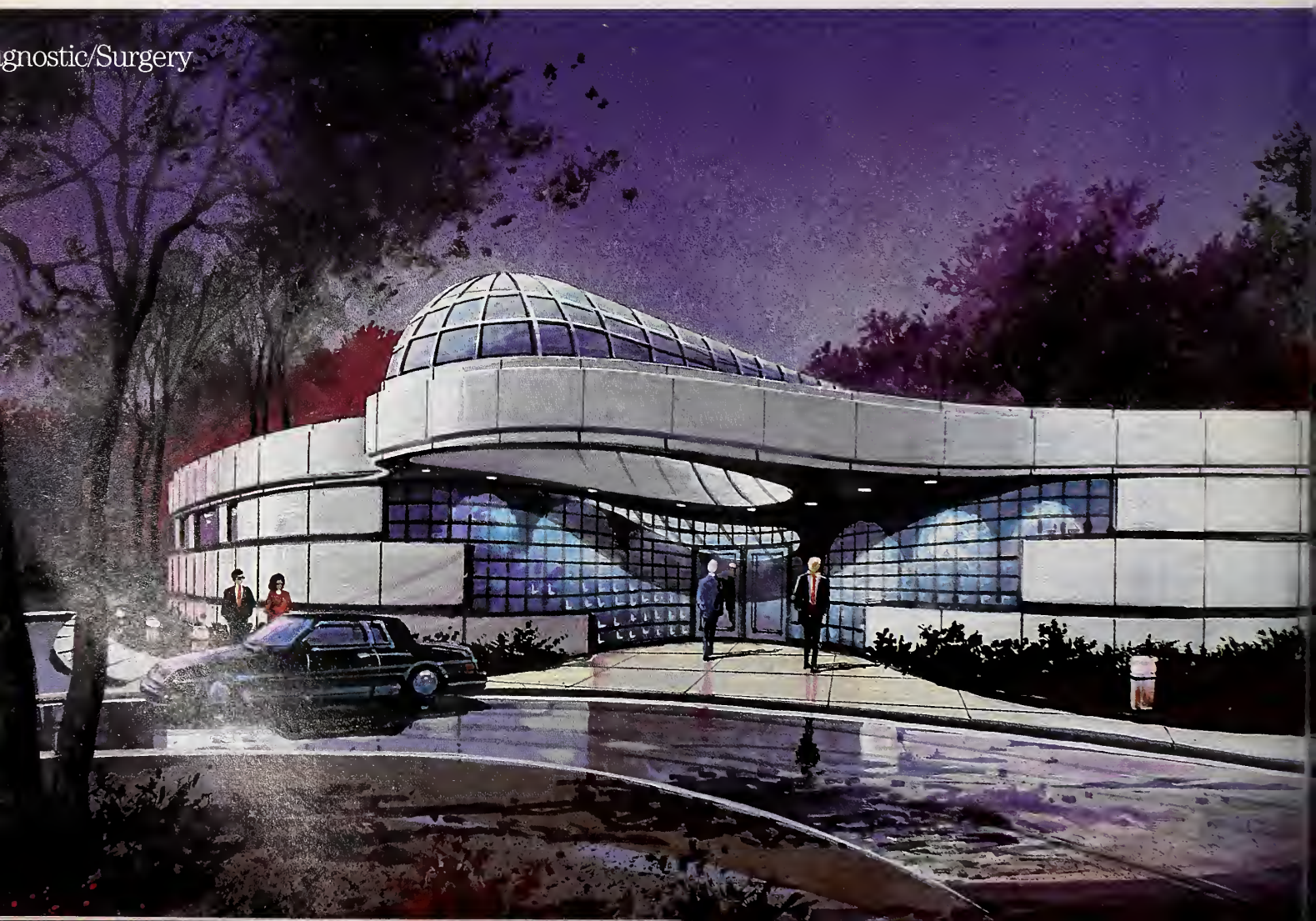
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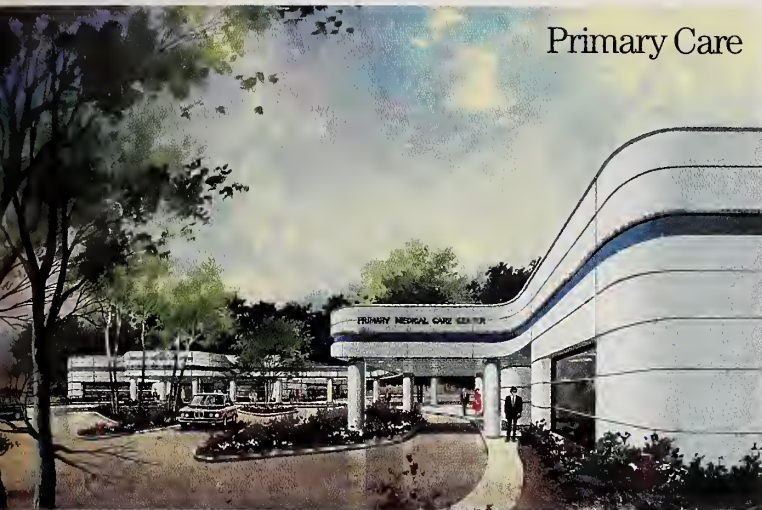
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# Georgia's Public Health Experience with Diabetes Control

Joy W. Hartley, M.P.H., Jerry P. Brown, Terry D. Golden, M.D.

## Historical Perspective

**I**N 1974, Congress established the National Commission on Diabetes to report on diabetes in the United States and make recommendations for reducing problems related to the disease. In 1975, when the report was issued, one of the many recommendations was for the Centers for Disease Control (CDC) to fund state-based Community Demonstration Projects. Funds were given to Georgia and seven other states to apply successful communicable disease epidemiologic techniques to chronic disease.

Georgia started demonstration projects in Lowndes County (Valdosta) and Ware County (Waycross) designed to overcome factors identified as contributing to excess diabetes morbidity and mortality. (See Drs. Barker and Stachura's article on p. for further discussion of the Valdosta project.) The three major factors identified were: 1) lack of patient education; 2) lack of current diabetes knowledge among professionals caring for individuals with diabetes; and 3) lack of coordination of diabetes resources.

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**Federal funds were allocated to Georgia with the understanding that the state would become technically and financially self sufficient. The state was also expected to seek state funding to supplement or replace federal funds.**

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Ms. Hartley is the epidemiologist and Mr. Brown is the program manager, Georgia Diabetes Control, Stroke, and Heart Attack Prevention, Kidney Disease, and Rape Crisis Programs, Georgia Department of Human Resources; Dr. Golden is in the private practice of internal medicine with a subspecialty in diabetes.

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The Georgia Diabetes Control Program designed several interventions to overcome these problems. The Georgia Department of Human Resources had a contract with Emory University and Grady Memorial Hospital to provide professional education in Atlanta for health professionals from across the state. A contract was entered into with the Medical College of Georgia to design and implement a Diabetes Education Program for health care professionals that could be held at different locations in the state. Both of these programs have been successful, with over 2500 professionals having completed these courses.

Patient education was improved by developing diabetes patient education courses initially in the Valdosta and Waycross Districts. Three more districts (Rome, Columbus, and Albany) were added in subsequent years. All of the diabetes programs in the districts are carried out at the local level in conjunction with the statewide Stroke and Heart Attack Prevention Program that began in Georgia in 1974. These programs

**TABLE 1 — Georgia Department of Human Resources Diabetes Control Program**

<i>District Diabetes Programs</i>	<i>Contact Persons</i>	<i>Phone Numbers</i>
1. Albany Health District Paul C. White, Jr., M.D.	Gayle Womble, R.N. 1109 N. Jackson St. Albany, GA 31708	(912) 430-4576
2. Columbus Health District Craig S. Lichtenwalner, M.D.	Connie King, R.N. 1353 13th Ave. Columbus, GA 31901	(404) 324-1918
3. Dublin Health District George Patterson, M.D.	Donna Forth, R.N. 2121-B Bellevue Rd. Dublin, GA 31021	(912) 275-6545
4. Rome Health District Darrell Dean, D.O.	Margaret Bean, R.N. N.W. Georgia Regional Hospital Building 614 1305 Redmond Rd. Rome, GA. 30161	(404) 295-6648
5. Valdosta Health District Lynne Feldman, M.D.	Gene Godfrey, R.N., F.N.P. P.O. Box 5147 Valdosta, GA 31603	(912) 333-5290
6. Waycross Health District John T. Holloway, M.D.	Delores Harlowe, R.N. 1101 Church Street Waycross, GA 31501	(912) 285-6037

have delivered comprehensive education to over 4000 individuals with diabetes to improve their basic understanding of the disease and to improve self care.

Coordination of diabetes resources was enhanced by the formation of an Advisory Committee which included representatives from major health providers caring for persons with diabetes within the state. Among the many agencies collaborating with the Diabetes Control Program are the American Diabetes Association, Georgia Affiliate; Grady Memorial Hospital; Medical College of Georgia; University of Georgia Center for Continuing Education; Diabetes Association of Atlanta; American Association of Diabetes Educators; and federal and state funded Primary Care Centers.

#### **Education**

Patient education courses given in these district programs were based in part on findings from the Diabetes Clinic at Grady Memorial Hospital. These findings showed that morbidity from diabetes could be reduced when patients were instructed in diet and other aspects

of self-care. Hospital admissions for preventable problems were reduced in Grady patients, and amputations were reduced dramatically with podiatric care in the Diabetes Clinic. The underlying

### **The coexistence of hypertension with diabetes is being addressed in collaboration with the Georgia Stroke and Heart Attack Prevention Program.**

principles in these successes were incorporated into the district diabetes programs.

Professional education was accomplished through several avenues. Physicians, nurses, and nutritionists in public health and in the local community were encouraged to attend the Grady Memorial Hospital week-long comprehensive clinical course in diabetes care, which is available at no cost to res-

idents of Georgia who care for persons with diabetes. For those professionals unable to come to Atlanta, MCG agreed to conduct local diabetes education programs for qualified professionals in a 2 day course. This program has been conducted in many sites statewide. Both the Grady Course and the MCG Course emphasize control of blood sugar, weight loss, and the avoidance of acute problems.

#### **Prevention of Complications**

Data from numerous national studies showed that some of the major complications of diabetes, such as blindness, loss of lower extremities, and perinatal problems, were largely preventable. The National Diabetes Advisory Board, successor to the National Commission on Diabetes, developed a "Prevention and Treatment of Five Complications of Diabetes — A Guide for Primary Care Practitioners." This booklet, which shows how to reduce morbidity from several complications by 50%, was distributed to physicians and other health care professionals interested in diabetes care.

The Georgia Diabetes Control Program began to conduct eye ex-



aminations every year on all Health Department patients at high risk for diabetic eye disease. After 2 years, examinations on district diabetes patients have identified over 370 eyes with complications secondary to diabetes. Over 65% of the treatable cases have already received treatment. The Georgia Affiliate of the American Diabetes Association, in cooperation with the Georgia Diabetes Control Program, the Georgia Lions, and the Georgia Lions Lighthouse, is conducting screening examinations for diabetic eye disease and referring persons with positive findings to eye specialists for diagnostic examinations. These screenings are done in areas not served by district diabetes programs. The ophthalmologic, the optometric, and the general medical communities as well as the general public have been most cooperative in supporting this project.

In district diabetes clinics, all females 15-44 years of age are counseled to ensure euglycemia prior to pregnancy and throughout gesta-

tion. All pregnant women with diabetes are referred to the High Risk Pregnancy Program for prenatal care and delivery.

The coexistence of hypertension with diabetes is being addressed in collaboration with the Georgia Stroke and Heart Attack Prevention Program. Blood pressures are taken at each visit, and close coordination with referring physicians ensures optimum monitoring of these patients.

The improved foot care intervention seeks to document the foot care being given to the health department diabetes clinic patients. Careful examination of the feet of each patient at each visit has been standard practice in the diabetes clinics.

#### Funding

Federal funds were allocated to Georgia with the understanding that the state would become technically and financially self sufficient. Training for state staff was sup-

ported by CDC to develop the managerial, epidemiologic, and medical skills needed to begin and maintain a Diabetes Control Program. The state was also expected to seek state funding to supplement or replace federal funds.

Georgia received \$150,000 in federal seed money the first year, and the Diabetes Control Program was able, with the assistance of the Advisory Committee and with strong support at the local level, to obtain state funds in the amount of \$145,000 in addition to the \$40,000 for the Grady Program. Since that time, state funds have grown to almost \$700,000 annually. With the beginning of a program in the Dublin District this year, diabetes programs are in 6 of 19 health districts. Efforts are being made each year to obtain funding to expand the diabetes program so that it will eventually be a statewide program that provides care and management to the diabetes population, specifically to those who could not receive care or education privately.

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# Diabetic Retinopathy

John A. Davidson, M.D., F.A.C.S., Shelby R. Wilkes, M.D.

**A**PPROXIMATELY 11 million Americans have diabetes mellitus, and every year nearly 5,000 people lose their sight as a consequence of this condition. Diabetic retinal involvement, rather than cataracts or glaucoma, is the leading cause of blindness in persons between the ages of 20 and 60. Ten years ago, diabetic eye involvement was the fourth cause of blindness. Advances in medicine, including the increased availability of insulin, have resulted in a longer life expectancy for persons with diabetes. However, the extended life span has also resulted in a higher incidence of late vascular complications, including diabetic retinopathy. Compared to the general population, a person with diabetes has twice the risk of developing glaucoma and five times the risk of cataract formation. An 8-year follow-up conducted in Denmark found the risk of blindness to be 50 to 80 times higher among people with diabetes than in the general population.<sup>1</sup>

## Classification

Diabetic retinopathy is divided into major types, nonproliferative

or background retinopathy and proliferative or new vessel retinopathy. Both types may be present for years with no signs or symptoms. Background retinopathy, the most common, frequently does not cause significant loss of vision. Retinal

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### **An important factor leading to blindness from diabetic retinopathy is lack of timely diagnosis and treatment.**

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microaneurysms, dot and blot hemorrhages, hard exudate (lipoprotein), and macular edema with retinal thickening may form in the paramacular area. These retinal changes can wax and wane, fre-

quently disappearing or at least stabilizing, with good vision about 80% of the time. Lipoprotein and macular edema with retinal thickening can severely decrease central vision.

Proliferative retinopathy, the most serious form of the disease, can lead to loss of all vision in the diabetic eye. Abnormal new vessels, or neovascularization, form on the optic nerve (NVD) or elsewhere on the retina (NVE). The NVD location has a poorer prognosis for conservation of vision than the NVE location.

The presence of retinal neovascularization (NVD or NVE) has no symptoms unless new vessels bleed. Hemorrhaging either in front of the retina or into the interior of the eye (the vitreous cavity), causes "floaters" or a painless severe decrease of vision, depending on the amount and location of the intraocular blood. If over time, from months to years, neovascularization continues to form and intraocular bleeding continues, retinal and intravitreal fibrosis can develop. The consequence can be permanent loss of vision secondary to chronic, nonclearing intravitreal blood and fibrotic traction retinal detachment.

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## Incidence

Diabetic retinopathy increases with duration of diabetes. After 10 years, 50% of diabetic patients have retinopathy, after 15 years, 70%, and after 25 years, 95%. Among patients with Type II, non-insulin dependent diabetes, approximately 50% have retinopathy after 20 years, with 10% having proliferative retinopathy. Among patients diagnosed with Type I, insulin dependent diabetes before the age of 30, approximately 90% experience retinopathy after 20 years. In about 50% of these patients, potentially blinding proliferative retinopathy will develop. Several factors in addition to duration of diabetes increase the severity of retinopathy: being male, certain HLA-DR factors, degree of hyperglycemia, higher systolic or

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## **Laser photocoagulation is the most effective available treatment for prevention of severe visual loss and blindness in both types of diabetic retinopathy.**

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diastolic blood pressure, higher pulse rate, diabetic neuropathy, and pregnancy. Retinopathy may temporarily worsen during tight metabolic control with insulin.<sup>2</sup>

## Pathogenesis

The pathogenesis of diabetic retinopathy has not been proven. Platelet and red blood cell aggregation with increased blood viscosity may produce retinal capillary occlusion and non-perfusion. Retinal ischemia may produce a (hypothetical) vasoproliferative factor in the retina and vitreous to stimulate growth of retinal new vessels.

Strict metabolic control of the disease, control of systemic blood pressure, the role of aspirin and aldose reductase inhibitors all appear encouraging to decrease diabetic retinopathy, but final results from ongoing clinical trials have not been completed.

## Treatment

Laser photocoagulation is the most effective available treatment for prevention of severe visual loss and blindness in both types of diabetic retinopathy.<sup>3</sup> Two well controlled, multi-center collaborative therapeutic studies, the Diabetic Retinopathy Study (DRS) and the Early Treatment Diabetic Study (ETDS), have presented evidence that timely laser treatment can significantly decrease and lessen the progression of severe visual loss.

After a 6-year period, the DRS demonstrated that eyes with proliferative retinopathy had 16% severe vision loss in laser-treated eyes, compared to 38% severe vision loss in non-treated eyes. In background retinopathy, the ETDS showed that patients with macular grid laser therapy had a 12% worsening of vision compared to a 25% worsening of vision in non-treated eyes. Timely laser treatment may decrease severe loss of vision from diabetic retinopathy by more than 50%.<sup>3</sup> In blindness which has resulted from chronic intravitreal hemorrhaging, intravitreal fibrosis, and fibrotic traction retinal detachment, about 50% visual improvement may be obtained from pars plana vitrectomy, an intraocular surgical procedure.

An important factor leading to blindness from diabetic retinopathy is lack of timely diagnosis and treatment. The ophthalmologist, utilizing yearly dilated pupil ophthalmoscopy, fundus photography, and fluorescein angiography when indicated, is the appropriate specialist to diagnose diabetic retinopathy. Controlled studies have shown non-ophthalmic physicians to have a 50% error rate in diagnosing di-

abetic retinopathy, as compared to a 9% error rate for the general ophthalmologist and a 0% error rate for the vitreous surgeon.

The following patients should be referred for retinal evaluation: 1) Type I patients, ages 10-30, with known diabetes for more than 5 years duration; 2) Type II patients, at the time of diagnosis and at 30 years of age; 3) insulin-dependent women anticipating pregnancy or in the first trimester of pregnancy.

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## **Diabetic retinopathy increases with duration of diabetes. After 10 years, 50% of diabetic patients have retinopathy, after 15 years, 70% and after 25 years, 95%.**

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## Summary

Retinal involvement from diabetes mellitus is the leading cause of new blindness in the United States. Many diabetic patients, though they have perfect vision and no ocular complaints or symptoms, harbor retinal pathology capable of leading to severe loss of vision. Therefore, all medical personnel caring for the diabetic patient must recognize the importance of dilated pupil retinal examinations by an ophthalmologist or vitreoretinal surgeon. Lack of timely diagnosis and treatment is a major factor leading to blindness from diabetic retinopathy. On a more positive note, prompt laser treatment of diabetic retinopathy can reduce severe visual loss by more than 50%.

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# The Georgia Diabetic Retinopathy Screening Study

Shelby R. Wilkes, M.D., John A. Davidson, M.D., F.A.C.S., Sue Munson, M.S., Jerry Freeman, M.S.

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**This study was partially supported and funded by the Georgia Affiliate of the American Diabetes Association, the Lions Lighthouse International Foundation, the Georgia Department of Human Resources, and the Centers for Disease Control.**

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**D**IABETIC RETINOPATHY represents a major cause of new blindness in persons aged 20 through 74 years old in the United States. Each year, 5000 people lose their sight because of diabetes. According to the American Diabetes Association, 20% of all people with diabetes are either black or Hispanic. The rate of non-insulin dependent diabetes is 33% higher in blacks and 300% higher in Hispanics. Over 20% of the adults in some Native American Indian tribes have diabetes. Disproportionately, blacks, Hispanics,<sup>1</sup> Asian-Americans, and Native Americans are affected by diabetes mellitus. Moreover, the Centers for Disease Control in Atlanta estimates that 125,000 citizens of Georgia have undiagnosed and undetected diabetes mellitus.

## **The Georgia Diabetic Retinopathy Screening Study**

Impetus for the statewide Georgia diabetic retinopathy screening study burgeoned in 1987 when a

preliminary non-randomized pilot screening study for diabetic retinopathy was performed by several Atlanta vitreoretinal surgeons. In conjunction with the Georgia Affiliate of the American Diabetes Association and an Atlanta area hospital, at least 28 persons with known diabetes mellitus and no history of a comprehensive dilated eye examination for at least 1 year were screened based on a written protocol. The results showed that five participants in the pilot study had diabetic retinopathy, and two of these needed laser photocoagulation. In addition, some of the participants with undetected diabetic retinopathy had been followed by ophthalmologists as well as endocrinologists for several years.

The purpose of this 3-year study is four-fold: 1) to screen at least 15,000 persons for possible diabetic retinopathy with known diabetes mellitus of at least 1 year in duration and with no history of a dilated eye examination by an

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ophthalmologist over the past year; 2) to increase the public's awareness and education of the risks of diabetic retinopathy; 3) to emphasize the need for *annual comprehensive dilated eye examinations* by an ophthalmologist; and 4) to reduce by 50% the rate of the risk of severe visual loss due to diabetic retinopathy to the citizens of Georgia.

## Materials and Methods

### Eligibility

Participants were eligible for screening for diabetic retinopathy if they were known diabetics and met at least one of the following criteria: 1) no history of a comprehensive dilated eye examination by an ophthalmologist over the past year, 2) at least 10 years of age, or 3) a member of a minority group i.e., blacks, Hispanics, Asian-Americans, and Native Americans.

### Screening

Designated communities for screening were notified at least 1-2 months in advanced of the actual date of screenings. Publication of screening dates and sites was via local radio announcements, television ads, and the local newspaper. The screening data obtained from participants for the Georgia statewide diabetic retinopathy were as follows: 1) name, age, sex, race and social security number; 2) duration and type of diabetes mellitus (I or II); 3) date of last eye examination; 4) visual acuity, (Snellen) primarily distance; 5) intraocular tension (with the pneumotonometer and applanation); and 6) measurement of the systemic blood pressure.

### Photography

Fundus photography with a non-mydriatic camera<sup>2,3</sup> was used to take three pictures of the posterior pole of at least 45 degrees including the (a) optic disc and macula, (b) superior to the superior vascular arcade (1-2 disc diameters), and (c) 1-2 disc diameters inferior to the inferior vascular arcade.

Fundus photographs were made on 35 mm color slides and read primarily by three vitreoretinal sur-

**TABLE 1 — Fundus Photographs Results of the Georgia Diabetic Retinopathy Screening Study**

	<i>Total</i>	<i>Percentage</i>	<i>Diabetic Retinopathy**</i>
Whites	2640	78.17	32
Male	1053	31.18	14
Female	1587	46.99	18
Blacks	688	20.37	6
Male	168	4.97	0
Female	520	15.39	6
Hispanics	49	1.45	0
Male	13	.38	0
Female	36	1.06	0
Total	3377*		

\*Over 4000 screened as of 7-1-89. \*\*Greater than 100 participants have

**TABLE 2 — Age Analysis of Participants**

<i>Age in years</i>	<i>Total Participants</i>	<i>Percentage</i>
Less than 30	225	6.66
30-44	457	13.53
45-64	1421	42.07
Over 65	1274	37.72
Total Participants	3377*	

\*Over 4000 as of 7-1-89.

geons. These fundus photos were graded for signs of the following: (a) no diabetic retinopathy or mild diabetic retinopathy, (b) moderate to severe background diabetic retinopathy or proliferative diabetic retinopathy and (c) whether photos were adequate for diagnosis. Recommendation for follow-up was as follows for the categories noted above: (a) ophthalmologic exam within one year, (b) immediate ophthalmologic appointment, and (c) ophthalmologic exam within a year or sooner if necessary. These recommendations were mailed to participants after the fundus photographs had been read.

## Results

After 1 year of the Georgia statewide screening study for diabetic retinopathy, 3377 persons had fundus photographs taken (Table 1).

There were 2640 (78.17%) whites, 688 (20.3%) blacks, and 49 (1.45%) Hispanics. Of those screened, 99 were found to have diabetic retinopathy and associated eye diseases. Associated eye diseases included maculopathy, cataracts, glaucoma suspects, and miscellaneous conditions. Thirty-eight people had only diabetic retinopathy.

Age analysis of the participants is shown in Table 2. The highest incidence (42.07%) occurred in the 45-64 year age group.

A total of 758 people reported that they had never had an eye examination. There were 1256 persons with elevated blood pressure, often associated with diabetic retinopathy. Further follow-up information regarding additional participants who had diabetic retinopathy and needed treatment is currently being established.



## Discussion

Minorities, including blacks, Hispanics, Asian-Americans, and Native Americans, are disproportionately affected by diabetes mellitus and diabetic retinopathy. The results of this study indicate that the minorities who are at higher risk than the general population of developing visual loss due to complications of diabetes are not proportionately being screened and/or reached based upon their per cent of the general population of Georgia. Intense planning and further selected screenings need to be done to address this disparity in this study.

Public and professional education is a major goal of this 3-year study. It is of interest that at least 758 participants out of the 3377 who were screened reported that they had never had an eye examination.

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**Since diabetic retinopathy requiring treatment can be present in patients with normal vision, such patients should obtain an annual dilated eye examination by an ophthalmologist.**

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Diabetic patients should have an annual comprehensive dilated eye examination, according to the American Academy of Ophthalmology. With the cooperation of volunteers from the ADA-GA Affiliate, the Lions Lighthouse International Foundation, the Georgia De-

## QUICK FACTS

**Diabetic retinopathy is a major cause of new blindness in the U.S. in persons aged 20-74 years old.**

**Annual comprehensive dilated eye examinations are recommended.**

**Diabetic retinopathy requiring treatment can be present even in patients with normal vision.**

**Minorities, including blacks, Hispanics, Asian-Americans, and Native Americans are disproportionately affected by diabetes mellitus and diabetic retinopathy.**

**Eleven million Americans have diabetes mellitus.**

partment of Human Resources, the Centers for Disease Control, the ophthalmologic community, the general medical community, and the public, the goals of the Georgia statewide diabetic retinopathy screening study are being reached.

The role of early treatment of diabetic macular edema<sup>4</sup> and the benefits<sup>5</sup> of therapy for proliferative diabetic retinopathy in reducing the risk of severe visual loss have been demonstrated in randomized clinical trials. These trials were supported by the National Eye Institute and conducted at leading ophthalmologic centers across the United States.

## Summary

The diabetic retinopathy screening study represents a major collaborative effort of many volunteer groups interested in decreasing the risk of severe visual loss to Georgia

citizens. Results of the present study have stimulated intense interest in screening more high risk persons, such as minorities, without the exclusion of whites. While age-related macular degeneration is the predominant cause of blindness in the U.S., diabetic retinopathy is a major new cause of blindness.

With the continuation and completion of this study, we believe that many more of Georgia's citizens will seek ophthalmologic examinations and benefit from previous research regarding the use of laser photocoagulation and vitreoretinal surgery in preventing or reducing the risk of blindness. Since diabetic retinopathy requiring treatment can be present in patients with normal vision, such patients should obtain an annual dilated eye examination by an ophthalmologist.

The value of statewide screening for undetected diabetic retinopathy, the determination of how and where to screen in order to give the most benefit to the potentially affected individuals and citizens of Georgia are only a few of the questions that may be answered when this study is completed. Moreover, to our knowledge this study is the first statewide screening for diabetic retinopathy in the United States.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

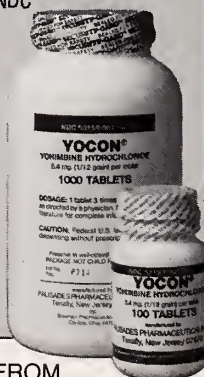
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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# Hypertensive Therapy for Diabetic Patients

James W. Reed, M.D., F.A.C.P.

**T**HE PREVALENCE ratio of hypertension in diabetics is approximately 2.0 (1.5-2.6) compared to nondiabetics.<sup>1</sup> With an estimated 22 million diabetics in the United States, only half of whom have been diagnosed, this presents a major problem for physicians. It is also estimated that less than half of all patients with both hypertension and diabetes have their blood pressure under control. This is consistent with the degree of control in the general hypertensive population.

In treating the patient with diabetes and hypertension, one must consider and manage routine complications that may be present at the time therapy is initiated. These problems include nephropathy, impotence, hyperlipidemia, coronary artery disease, heart failure, and orthostatic hypertension. The hypertensive diabetic patient therefore needs a thorough clinical evaluation prior to instituting therapy. This would include testing for glucose and lipid control, cardiac output, electrolytes, renal function, and blood volume.

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## **One must be especially conscious of the complications that antihypertensive therapy may induce in diabetics.**

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The first step should be a non-pharmacological approach. This would include diet, sodium restriction, potassium, calcium and magnesium supplementation when appropriate, weight reduction, and adequate exercise.<sup>2</sup> Stress management can also be very helpful in controlling both diabetes mellitus and hypertension. If we add to this regimen cholesterol restriction and adequate polyunsaturated fats, we

have addressed the major contributors to macro-vascular disease in the diabetic patient as well as in the general patient population. Six to twelve weeks is a reasonable time-frame for evaluating a non-pharmacological approach.

It is the recommendation of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure that a blood pressure level of 140/90 should be the goal of therapy in the general population.<sup>3</sup> However, because of the accelerated vascular complications in diabetes mellitus, it has been suggested that a lower blood pressure is indicated for patients who have both diabetes and hypertension. It is my recommendation that a target of 135/85 be established.

**D**rugs recommended as first line therapy for essential hypertension in a diabetic patient are diuretics, angiotensin-converting enzyme (ACE) inhibitors, or calcium-channel blockers.<sup>3,4</sup> If a diuretic is chosen, it should be given

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in the smallest therapeutic dose (thiazide, no greater than 25 mg). Thiazide diuretics may cause potassium depletion further complicating glucose control in Type II diabetes, and they may also cause elevation of blood lipids. If an ACE inhibitor is chosen, one must be aware of the patient's renal status. However, mild elevations of creatinine is not a contra-indication to ACE inhibitors in diabetic patients.

ACE inhibitors have become increasingly accepted as first line therapy with diabetic patients. They have been found to have little adverse effect upon glucose and lipid control. It has also been demonstrated that renal function frequently improves when an ACE inhibitor is used to treat hypertension.<sup>5,6</sup> As monotherapy, ACE inhibitors have been shown to result in marked improvements in diabetic patients with mild to moderate hypertension.<sup>6</sup> Hypotensive episodes can be avoided by starting with a lower dosage, gradually adjusting it as indicated based on the individual patient's response.

## Diuretics have come under some criticism not only because of hypokalemia but also because of serum lipids elevation.

It is standard practice to combine an ACE inhibitor and a thiazide diuretic in small dosages to control hypertension in diabetics. If the patient's blood pressure is not adequately regulated with this approach, a calcium channel blocker

**TABLE 1 — Summary Approach to Hypertension in Diabetic Patients**

- I. Nonpharmacologic treatment
  - a. Diet aimed at weight control and lipid control
  - b. Exercise — tailored to individual
  - c. Moderate sodium restriction (2 gms Na<sup>+</sup>)
  - d. Potassium, calcium and magnesium supplementation
- II. If adequate blood pressure is not obtained, use a diuretic, ACE Inhibitor, or calcium channel blocker, as monotherapy.
- III. If control is not obtained with monotherapy, add second drug — from same group
- IV. If control is not obtained with the above information, add a third drug, from same group or a vasodilator.

may be substituted or added. A vasodilator is considered if blood pressure still remains at an unacceptable level.

One must be especially cognizant of the complications that antihypertensive therapy may induce in diabetics. Data from the Multirisk Factor Intervention Trial has caused concern about the use of diuretics as first line therapy in treating hypertension in the general patient population. Thiazide diuretics impair insulin release and glucose tolerance, probably via potassium depletion. Hyperinsulinemia forces potassium into cells and the diuretics promote kaliuresis. Some of these complications may be prevented by the use of potassium sparing agents. Since the diabetic patient is highly vulnerable to diuretic induced potassium loss, it is critical that serum potassium levels be carefully monitored.

Diuretics have come under criticism not only because of hypokalemia, but also due to elevation of serum lipids. Therefore, an ACE inhibitor has been recommended as initial therapy. (See Table 1) Beta blockers are not considered, by many, to be a first line therapy for diabetic patients. In the insulin dependent Type I diabetic, the beta blocking drugs may mask the signs and symptoms of hypoglycemia. In Type II diabetes, beta blockers may impede insulin secretion and make their glucose level more difficult to control.<sup>7</sup>

## Summary

The treatment of patients with both diabetes melitus and hypertension must take into account the increased risk of vascular complications. If an adequate trial of non-pharmacological therapy does not prove effective, drug therapy, tailored to the individual patient, is instituted. In this event, monotherapy should be the primary goal.

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# Lipoprotein Disorders in Diabetes Mellitus

W. Charles O'Neill, M.D.

## Lipoprotein Metabolism

**L**ipoprotein metabolism can be conveniently divided into two pathways. The exogenous pathway deals with dietary fat, which is packaged by intestinal cells into large, triglyceride-rich chylomicrons. The triglyceride is removed from chylomicrons by lipases during circulation, leaving a more cholesterol-rich remnant that is rapidly cleared by the liver. In the endogenous pathway, triglyceride-rich, very low density lipoprotein (VLDL) is secreted by the liver and again is acted on by lipases to yield a remnant particle (intermediate-density lipoproteins, IDL). These particles are then either cleared by the liver or are further catabolized to low density lipoproteins (LDL), a particle consisting almost entirely of cholesterol. The LDL is then taken up by the liver or by other tissues via the apolipoprotein B receptor.

Since the cholesterol backbone cannot be broken down by mammalian cells, there is a reverse cholesterol transport in which high density lipoprotein (HDL) picks up

cholesterol from peripheral cells and delivers it to the liver. The latter occurs indirectly through the interaction of HDL with lower density lipoproteins whereby cholesterol is donated to these particles prior to their uptake by the liver. This interaction of VLDL, chylomicrons, and remnants with HDL is responsible for the inverse relationship between the circulating levels of these particles. Thus, hypertriglyceridemia of almost any cause reduces HDL. By contrast, lowering the triglyceride level raises HDL.

Insulin significantly affects lipoprotein metabolism through induction of lipoprotein lipase synthesis, inhibition of lipolysis in adipose tissue (an important determinant of VLDL secretion by the liver), and synthesis of lipoproteins by the liver. It is not surprising then that lipid abnormalities are an integral feature of diabetes mellitus.

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## Lipoprotein Abnormalities in Type II Diabetes

Most of the attention has been focused on Type II diabetes since lipoprotein abnormalities are very common in this disorder. Typically VLDL is elevated, LDL is normal or elevated, and HDL is low. The primary disturbance appears to be increased lipolysis in adipose tissue due to the resistance of this tissue to insulin. This leads to increased delivery of free fatty acids to the liver, resulting in increased secretion of VLDL. This in turn results in increased catabolism of HDL. There are also qualitative abnormalities. The VLDL and VLDL remnants (IDL) contain excess triglycerides that eventually produce smaller, denser (decreased cholesterol to protein ratio) LDL particles. These particles are now recognized as being highly atherogenic.

In addition to these disturbances caused by diabetes, it is important to recognize that some lipoprotein disorders are associated with abnormal glucose tolerance. This is particularly true of Type V hyperlip-

idemia (elevated VLDL and chylomicrons) but can also be seen in Type IV hyperlipidemia (elevated VLDL). These patients are often overweight and have hyperuricemia as well. Triglyceride levels are usually over 2000 mg/dl, distinctly higher than the mild elevations seen in the typical patient with Type II diabetes, and are not normalized by treatment of the hyperglycemia.

Type I diabetes is generally not associated with quantitative lipoprotein abnormalities, except for the severely decompensated patient in whom insulinopenia reduces lipoprotein lipase and leads to chylomicronemia (Type I hyperlipidemia). This condition is easily recognized because of the lipemia retinalis and the creamy plasma, and resolves with insulin therapy. It is becoming apparent, however, that the normal lipoprotein levels in Type I diabetes are masking substantial alterations in lipoprotein content of triglyceride and in lipoprotein density. The clinical significance of these changes remains to be determined, but they appear to lead to LDL particles of increased atherogenicity.

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**Since cardiovascular disease is the leading cause of death in diabetes, it is imperative that prevention of atherosclerosis be a primary goal of management.**

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#### **Diabetes and Atherosclerosis**

Diabetes is an important risk factor for atherosclerosis that appears to be independent of LDL and HDL cholesterol. It is unclear if this is due to the other, more subtle, lipoprotein abnormalities in diabetes or to the effects of diabetes on vascular tissue. Both probably play a role, although the consensus is that

the latter is more important. This may explain why diabetes predisposes to diffuse atherosclerosis, while elevated LDL is a potent risk factor only for coronary artery disease (CAD).

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**Controversy still exists about increased triglyceride as a risk factor for coronary artery disease, but the evidence is strongest in females and diabetics.**

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It is important to remember that diabetes has a particularly devastating effect in females, essentially negating their reduced risk of developing CAD. Whereas normal men have three times the risk of developing CAD as have normal women, diabetic men and women have similar incidences of CAD. Diabetes also potentiates the effect of other risk factors, particularly smoking and hypertension. Since cardiovascular disease is the leading cause of death in person with diabetes, it is imperative that prevention of atherosclerosis be a primary goal of management. In addition to controlling hyperlipidemia, these other risk factors must be eliminated.

#### **Treatment of Lipid Disorders in Diabetes**

There have been very few clinical studies aimed at the treatment of hyperlipidemia in diabetes, and there have been no intervention trials indicating that treatment of hyperlipidemia reduces the incidence of CAD in people with diabetes. The hypertriglyceridemia in Type II diabetes is rarely to the degree that predisposes to pancreatitis. Controversy still exists about increased triglyceride levels as a risk factor for CAD, but the evidence is strongest in females and diabetics. However, whether treatment of hypertriglyceridemia will reduce this risk is unknown.

Low HDL, which is common in Type II diabetes, is well-recognized as a risk factor for CAD. Evidence that raising HDL cholesterol will decrease CAD risk is accumulating, but this has not yet been conclusively demonstrated. Treatment directed primarily at raising HDL should therefore be limited to non-pharmacologic measures (weight loss, exercise, cessation of smoking), which are already a standard part of the treatment of Type II diabetes. Attention should be focused mainly on elevated LDL cholesterol, since intervention trials have demonstrated conclusively that lowering LDL cholesterol reduces CAD (although this has not been shown in diabetes). Current NIH guidelines suggest that LDL cholesterol be lowered when it is

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**Insulin significantly affects lipoprotein metabolism through induction of lipoprotein lipase synthesis, inhibition of lipolysis in adipose tissue, and synthesis of lipoproteins by the liver.**

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above 160 mg/dl, or 130 mg/dl when two other risk factors for CAD are present (low LDL, male sex, smoking, diabetes, hypertension, severe obesity, family history of CAD). Since most patients with Type II diabetes have more than one additional risk factor, LDL cholesterol levels above 130 mg/dl will require attention.

A fasting lipid profile should be obtained in all patients with Type II diabetes. The first step in treating any abnormalities is controlling the diabetes. Some cases of severe hypertriglyceridemia are associated with and exacerbated by diabetes. However, they are not necessarily



**It is becoming apparent that the normal lipoprotein levels in Type I diabetes are masking substantial alternations in lipoprotein content of triglyceride and lipoprotein density.**

a result of the diabetes and treatment should be directed at both the hypertriglyceridemia and the diabetes. Unfortunately, adequate control of Type II diabetes is not obtainable in many patients, and

specific therapy to lower LDL will be required.

The first step is a lipid-lowering diet (30% or less of calories as fat, including no more than 10% of calories as saturated fat, 300 mg cholesterol) which is essentially identical to the standard diabetic diet. If LDL cholesterol remains above 190 mg/dl (or 160 mg/dl when an additional risk factor is present) pharmacologic therapy should be instituted. Bile acid sequestrants (colestipol, cholestyramine; 2 doses with each meal) should be used with caution since they can elevate VLDL. Niacin (or nicotinic acid; up to 1.5 g with meals) can be very useful since it raises HDL in addition to lowering LDL and VLDL. However, it is not well tolerated and

it may increase glucose intolerance.

Lovastatin (20 mg qd to 40 mg bid) is a well-tolerated drug that has been shown to effectively lower LDL without raising VLDL in people with diabetes. Gemfibrozil (600 mg bid), which also raises HDL, is an excellent drug for treating hypertriglyceridemia. However, because it is only mildly effective in lowering LDL, actually increasing LDL in some patients, it is not recommended for this purpose. Fish oils may have beneficial effects both on lipid levels and directly on vascular tissue but since they generally raise LDL levels and may have other detrimental effects, they should be considered experimental at this time.

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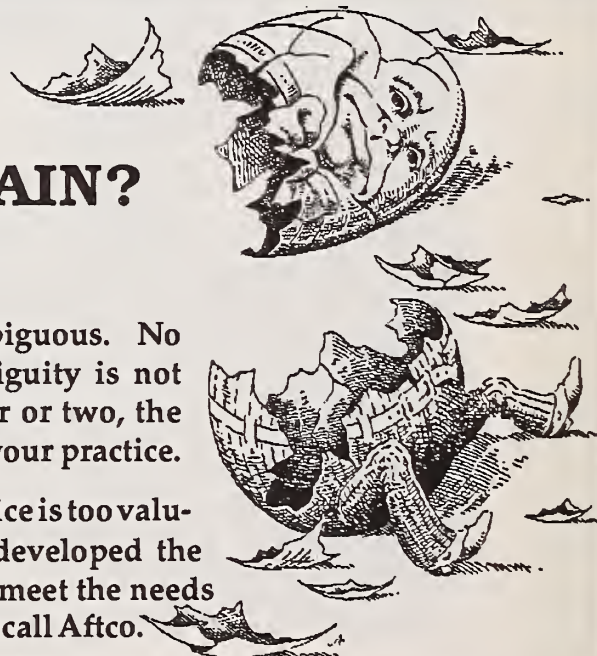
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# Management of Diabetes During Pregnancy

Y. Khalid Siddiq, M.D.

## Introduction

**D**IABETES MELLITUS is one of the most common medical problems encountered in pregnancy. It occurs both in an established diabetic woman who becomes pregnant and in a previously non-diabetic woman who develops diabetes during pregnancy, a condition known as gestational diabetes. Gestational diabetes occurs in 2% of all pregnant women, resulting in 60-90,000 cases of gestational diabetes yearly.

## Background

Normal pregnancy is considered a diabetogenic state, since insulin requirements increase with each trimester. In early pregnancy, glucose homeostasis is altered by increasing levels of estrogen and progesterone which lead to beta cell hyperplasia and an exaggerated insulin response to glucose load. At the same time, pregnancy induces increased peripheral utilization of glucose, causing lower fasting glucose levels. During the second half of pregnancy, rising levels of human placental lactogen, cortisol, estrogen, and progesterone produce

insulin resistance. In this setting, women with decreased insulin reserve may develop gestational diabetes.

## Effect of Diabetes on the Fetus

Each year 10,000 babies are born to diabetic mothers. Prior to 1922 and the discovery of insulin, almost no infant of a diabetic mother survived. Unless hyperglycemia is controlled tightly, the morbidity is still significant, although optimum care by a team of experts can reduce the mortality substantially. Increased metabolic fuels, such as increased production of beta hydroxybutyrate, glucose, and amino acids in uncontrolled diabetes mellitus, and hyperosmolarity are believed to play a teratogenic role in the genesis of fetal malformations within the first 6 weeks of gestation and to stimulate fetal insulin production which may contribute to the development of large lethargic infants prone to hypoglycemia after birth.

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## Detection of Gestational Diabetes

Because most, if not all, of the complications of diabetic pregnancy appear to be associated with poor metabolic control, all pregnant women should be screened for glucose intolerance early in pregnancy. Pregnant women who have not been identified as having glucose intolerance before the 24th week should have a blood glucose measurement 1 hour after a 50 gm oral glucose load between 24-28 weeks without regard to time of day or time of last meal. Blood glucose values of 140 or above constitute an indication for full oral glucose tolerance test. Repeat testing beginning in the 3rd trimester is indicated in high risk women, such as those with glucosuria, first degree diabetic relatives, history of one or more abnormal pregnancies, maternal obesity, adverse maternal age and multiparity. Criteria for the diagnosis of diabetes in pregnancy is shown in Table 1 based on an oral glucose tolerance test. The test is performed by administering 100 gm of glucose after an overnight fast following at least 3 days of unrestricted diet.

**TABLE 1 — Screening for Diabetes in Pregnancy**

**Initial Screening**

For all pregnant women not known to have diabetes between 24-28 weeks gestation:

(test earlier if diabetes suspected)

50 gm. oral glucose (given randomly) with plasma glucose drawn 1 hour later.

Plasma glucose >140 mg/dl warrants an oral glucose tolerance test.

**Oral Glucose Tolerance Testing**

100 gm. oral glucose after overnight fast

Glucose criteria for diagnosis of diabetes:

Fasting  $\geq 105$  mg/dl

1 hour  $\geq 190$  mg/dl

2 hour  $\geq 165$  mg/dl

3 hour  $\geq 145$  mg/dl

At least two of the above must be present.

Women with diabetes who are contemplating pregnancy should have the benefit of early counseling. Pregnancy should not be discouraged on genetic grounds alone, since the risks of diabetes mellitus in offspring of diabetic mothers is considerably less than previously thought. Metabolic control during gestation rather than duration of diabetes in the mother appears to be an important factor in determining a successful outcome.

**Management of Diabetes in Pregnancy**

During normal pregnancy, plasma glucose can range from fasting values of <70 mg/dl to a peak value of 130 mg/dl. Since fetal organogenesis occurs during the first 6 weeks after conception, often before pregnancy is detected, the clinician who attends diabetic women should aim to achieve the same glycemic pattern before, as well as, during pregnancy. Thus, the optimum management of a diabetic pregnancy begins with careful pre-pregnancy planning.

Proper management of diabetes is best carried out by a team approach consisting of an obstetrician, diabetologist, pediatrician, nurse educator, dietician, and social worker. Three components of diabetic management are important to maintain euglycemia: diet, glucose monitoring, and insulin.

**Diet**

On average, women gain approximately 25 pounds during pregnancy. Attempts at weight reduction or starvation are contraindicated, since they have an adverse affect on the developing fetus. The patient should be prescribed 24-38 kcal/kg/d. The calories should be given as three meals and two snacks and distributed such that 20% of calories are given at breakfast, 5% in midmorning, 30% at lunch, 35% at supper, and 10% at bedtime.

**Home Glucose Monitoring**

The blood glucose should be monitored at least 4 times a day, with adjustments in insulin dosage made frequently in order to maintain euglycemia. Hemoglobin A1-c should be measured and the patient checked by her physician bi-weekly until 28 weeks and then every week thereafter. The goals for glucose control are as follows: fasting and premeal plasma glucose <90mg/dl and a 2-hour postprandial glucose <120 mg/dl.

**Insulin**

Insulin is indicated if diet therapy alone does not maintain diabetic women who have fasting and optimal glucose control. Sulfonylurea therapy is contraindicated during

pregnancy. Insulin requirements may vary but usually range between 0.3-0.4 units/kg LBW in the lean diabetic, and 0.5-0.7 units/kg LBW in the obese diabetic. Several different insulin strategies have been used: A combination of NPH and Regular with two-thirds of total dose given in the morning, one-third in the evening, and a ratio of NPH to Regular in the morning as two to one and in the evening one to one often works well; regular insulin before each meal with NPH or Lente at night is another option. Appropriate adjustments in the dose and type of insulin used must be addressed frequently in order to keep the patient euglycemic, since needs vary at different stages of pregnancy.

**Management During Parturition and Postpartum**

During parturition, the blood sugars may fall rather precipitously with significant risk of fetal and maternal hypoglycemia. Glucose, as 10% dextrose, given by IV may be required. Postpartum follow-up should include an oral glucose tolerance test in gestational diabetics. If glucose tolerance has returned to normal, these individuals will likely become diabetic with each pregnancy and carry about a 30% risk of developing diabetes later in life.

**Summary**

Evidence now exists that maintaining normal maternal plasma glucose in the diabetic mother results in an infant mortality risk equal to that in the general population and may reduce the late fetal complications of maternal diabetes: macrosomia and perinatal hypoglycemia.

Careful attention to diet, home glucose monitoring, multiple insulin injections, and frequent dose adjustments are often required to achieve this goal. Since organ development occurs within the first few weeks after conception, pregnancy planning and optimization of diabetes management prior to pregnancy is critical to good outcome in diabetic women eager to begin a family.■



# The Diabetic Foot: Protection and Preservation

Robert B. Chadband, M.D., Morton Wittenberg, D.P.M., Mary L. Ottinger, D.P.M.

**D**IABETES MELLITUS is a complex chronic metabolic disorder associated with destruction and disorganization of numerous tissues and physiologic processes. Diabetes has been implicated as a cause of vascular disease, neuropathy, alternation in immune responses, and ineffective tissue repair. Because of these multisystem failures, minor injuries and infections have the potential to evolve into limb-threatening lesions.

Over 50,000 major amputations of the lower extremity are performed each year in this country, and five out of every six of these surgeries are on people with diabetes. It should be the goal of health care professionals caring for people with diabetes to prevent, rather than treat, the complications of this disorder. Though some experts still feel that the prevention of diabetic microvascular disease through strict glycemic control is controversial, there can be no doubt that the majority of amputations can be prevented through programs of patient education and professional surveillance.

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**Assumption that a warm foot is a healthy foot can be misleading. Autonomic neuropathy can cause shunting of blood to superficial cutaneous vessels, depriving deeper tissues of adequate oxygenation.**

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The diabetic foot is frequently altered by sensory neuropathy which allows secondary and more serious damage to occur before the patient seeks medical assistance. Neuropathy, vascular disease, and an impaired immune system act in concert to produce serious infection or deformity which can significantly restrict ambulation and threaten limb viability. Complex le-

sions often are heralded by the development of more subtle changes such as callouses, muscle atrophy, soft tissue changes, and bony malposition. Ulcers, which develop on the diabetic foot represent advanced disease and should be considered a primary treatment failure. Professionals and patients alike must become aware of the three most common factors responsible for diabetic foot injury: skin breakdown, biomechanical fault, and neuropathy.

## What To Look For

### *Skin breakdown*

Hypoxia, resulting from peripheral vascular disease, promotes tissue injury and ineffective tissue repair. Obvious signs that tissue is at risk are loss of turgor, delayed capillary filling, decreased pulses, tissue cyanosis or pallor, and loss of extremity hair. Dryness of skin and cracking may also be present. Loss of plantar skin lines, which precedes callous formation, is an important sign which is often overlooked. Callouses, corns, and

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1. At each visit and at least yearly, check for:
  - A history of foot problems since last visit
  - A history of intermittent claudication
  - Pulses (dorsalis pedis, tibial, popliteal, femoral)
  - Bruits
  - Sensation (pin prick, vibratory, light touch) in toes and feet
  - Foot hygiene (callouses, cleanliness, presence or absence of deformities, bunions, fit of shoes)
  - Ulcers (note the presence or absence of pain and infection)
2. When there is any abnormality in history or physical assessment:
  - Ensure proper foot care, patient education, or collaborate with a qualified podiatrist to provide foot care
  - Repeat foot examination at each visit or at least every 6 months
3. When callouses exist:
  - Provide paliative care or refer to podiatrist to do so.
4. When deformity exist:
  - Patient requires consultation with a podiatrist or orthopedist with special interest in foot problems; would benefit from having special shoes fitted, or special orthosis in the shoe
5. When neuropathic ulcer with adequate blood supply exists:
  - Consult with a podiatrist, orthopedist, or diabetes specialist
6. When an ulcer with inadequate blood supply or infection exists:
  - Consult a specialist knowledgeable in the treatment of these lesions (diabetologist, vascular surgeon, orthopedist, podiatrist); and/or hospitalize patient for diabetes management and appropriate consultation

blisters signal mechanical faults causing excess pressure or friction to an isolated area. Callous formation, initially protective, becomes damaging by increasing the localized shear and stress on underlying tissue. Repeated low stress leads to hypertrophic skin response. Repeated high stress leads to fatigue and skin failure.

#### *Biomechanical fault*

Understanding of the complexity of foot injury requires an understanding of the complexity of foot function. The foot must function as a mobile adaptor and shock absorber during heel and stance phase by pronation, then become a rigid lever for propulsion by supinating. Exaggeration of either function, whether by degree or by sequence, leads to the production of many of these deformities: bunions, hammertoes, and metatarsal problems. Proper functional control of the lower extremity allows normal range of motion and sequence, thus reducing the negative effects of overpronation, over-supination, compensation, or limitation of motion.

Examine the foot for obvious signs of mechanical weakness, such as bunions, hammertoes, and metatarsal deformity. Look at the general shape of the foot while the patient is standing. A low-arched foot is typical of one undergoing over-

pronation. Other signs of this syndrome include genu recurvatum, genu valgum, external malleolar torsion, and an everted calcaneus.

### **Neuropathy, vascular disease, and an impaired immune system act in concert to produce serious infection or deformity which can significantly restrict ambulation and threaten limb viability.**

A high-arched foot is typical of one which is supinating excessively and may also demonstrate genu varum, restricted ankle dorsiflexion, and an inverted calcaneus.

During gait, observe timing of stance and swing phases, as well as position of the foot during heel contact, midstance, heel off, and toe off. Excessive pronators generally demonstrate an apropulsive gait, the foot appears to collapse medially, with very little push-off from the hallux. Over-supinators

demonstrate a slightly jolting gait, with the weight transfer remaining on the lateral side of the foot.

#### *Neuropathy*

In addition to muscle atrophy, diabetic peripheral neuropathy promotes insensate trauma. Loss of functional control is even more important in the neuropathic foot. Loss of proprioception combined with disorders of autonomic function are early manifestations of diabetic neuropathy. These abnormalities allow for inappropriate sensory feedback, resulting in increased numbers of falls, trips, or missteps leading to fractures and soft tissue injuries. Current information suggests that a "hot foot" or inflamed foot is a foot at high risk. Classic diabetic "Charcot" deformities frequently follow soft tissue or minor injuries and generalized extremity inflammation. The warm, hyperemic foot may lead health care providers into a false sense of security. Assumption that a warm foot is a healthy foot can be misleading. Autonomic neuropathy can cause shunting of blood to superficial cutaneous vessels, depriving deeper tissues of adequate oxygenation. Vasodilation and increased blood flow to the lower extremity may promote increased bony resorption (osteolysis).



## What To Do

The diabetic patient must develop the habit of daily foot inspection and become familiar with basic foot care principles. Patients who are unable to examine their feet must have someone else assigned to this task. Aside from a general visual examination of the feet, each medical checkup should include an inspection of the condition of the shoes, toenails, and skin. Palpation of the pulses and tests of proprioception, vibration, and pain sensation should be done regularly. Evidence of fungal infection or tissue injury requires prompt effective treatment.

All diabetics should be encouraged to wear only well fitting shoes, which are not made of plastic or have open or pointed toes. Shoes

---

**Five out of six of the 50,000 major amputations performed in the U.S. are on people with diabetes. The majority of these can be prevented through programs of patient education and professional surveillance.**

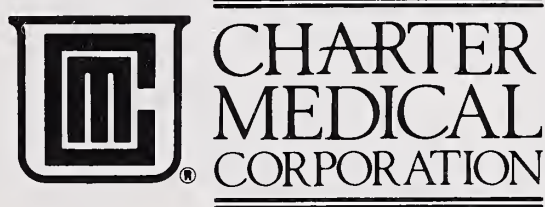
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should have low heels, sturdy shank, soft sole, and a rounded toe box with adequate depth.

When signs of biomechanical fault are present, the physician must evaluate the foot and consider what type of corrective device will best control the patient.

### When You Need Assistance

Any patient who demonstrates mechanical fault (bunions, hammertoes, plantar callous) needs proper mechanical care. Callous formation, by far the most common abnormality, requires meticulous debridement. If the health care provider is not well-versed in lower-extremity biomechanics or palliative care, it is recommended that the patient be referred to an experienced podiatrist or orthopedist with interest in this area.



## PHYSICIANS NEEDED

INTERNAL MEDICINE

FAMILY PRACTICE

ONCOLOGY

NEUROLOGY

HEMATOLOGY

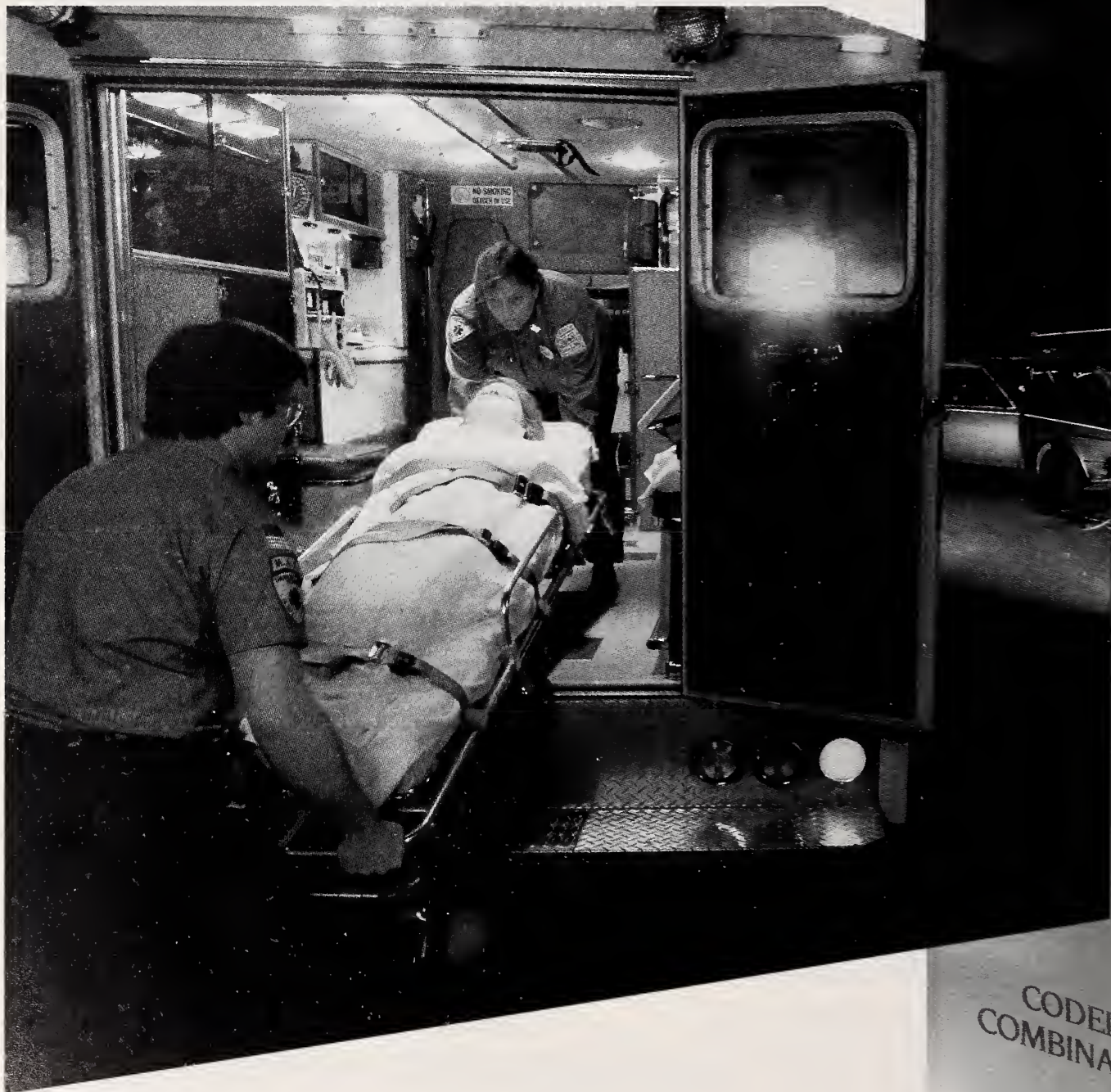
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Please contact Stephen Wofford collect at 912/741-6283 for a confidential consultation or write to Stephen Wofford, Director of Physician Recruiting, Charter Northside Hospital, P.O. Box 4627, Macon, GA 31208.

# From Route 16...



CODEINE  
COMBINATION



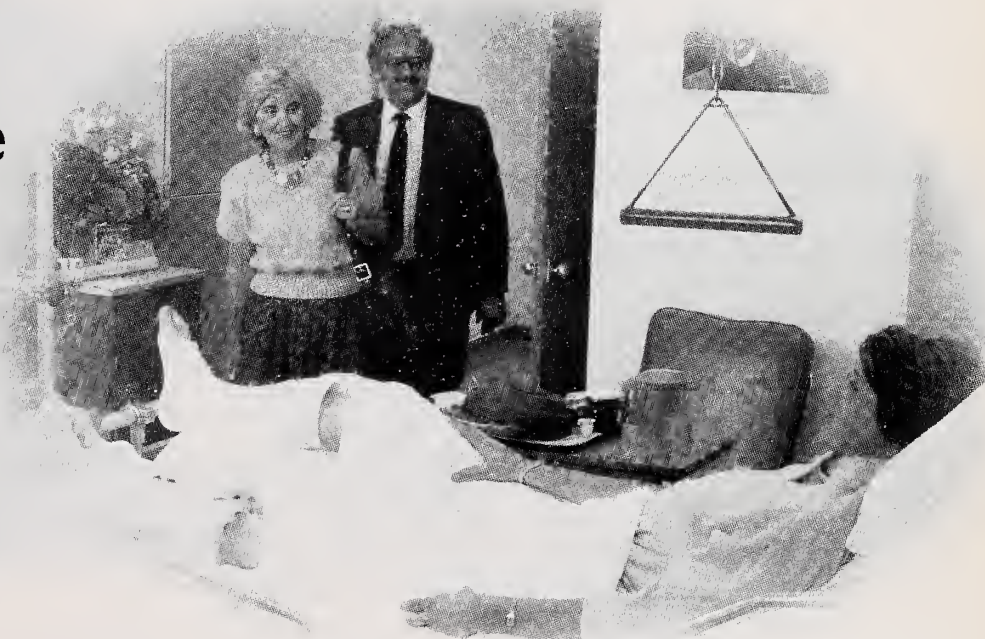
# to Room 16

Laura didn't remember the crash, but she did feel the pain, excruciating...unrelenting. Initially, you ordered DEMEROL® I.V. Later, you specified DEMEROL® Tablets for her recuperation in the hospital and her first days at home. DEMEROL for trauma...and other conditions that cause moderate to severe pain.

Your skills help save your patients' lives. DEMEROL can help relieve their pain.\*

DEMEROL. The only brand name of meperidine HCl you can specify that's available in a wide range of dosage forms.

**When morphine  
is too much...  
codeine  
combinations  
not enough**



# Demerol®

**TABLETS  
INJECTABLE  
SYRUP**

brand of meperidine HCl, USP

**The original for relief**

\*See next page for product information concerning contraindications, warnings, adverse reactions and prescribing and precautionary recommendations.

**Winthrop**  
PHARMACEUTICALS



# When morphine is too much... codeine combinations not enough

## Demerol® HYDROCHLORIDE Brand of MEPERIDINE HYDROCHLORIDE, USP

### DESCRIPTION

Meperidine hydrochloride is ethyl 1-methyl-4-phenylisopropylcarbamate hydrochloride, a white crystalline substance with a melting point of 186°C to 189°C. It is readily soluble in water and has a neutral reaction and a slightly bitter taste. The solution is not decomposed by a short period of boiling.

The syrup is a pleasant-tasting, nonalcoholic, banana-flavored solution containing 50 mg of DEMEROL hydrochloride, brand of meperidine hydrochloride, per 5 mL teaspoon (25 drops contain 13 mg of DEMEROL hydrochloride). The tablets contain 50 mg or 100 mg of the analgesic.

DEMOROL hydrochloride injectable is supplied in Carpuject® Sterile Cartridge-Needle Unit of 2.5% (25 mg/1 mL), 5% (50 mg/1 mL), 7.5% (75 mg/1 mL), and 10% (100 mg/1 mL). Uni-Amp® Unit Dose Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Uni-Nest™ Pak — ampuls of 5% solution (25 mg/0.5 mL), (50 mg/1 mL), (75 mg/1.5 mL), (100 mg/2 mL), and 10% solution (100 mg/1 mL). Multiple-dose vials of 5% and 10% solutions contain metacresol 0.1% as preservative.

The pH of DEMOROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid.

DEMOROL hydrochloride, brand of meperidine hydrochloride, 5 percent solution has a specific gravity of 1.0086 at 20°C and 10 percent solution, a specific gravity of 1.0165 at 20°C.

**Inactive Ingredients** — TABLETS: Calcium Sulfate, Dibasic Calcium Phosphate, Starch, Stearic Acid, Talc. SYRUP: Benzoic Acid, Flavor, Liquid Glucose, Purified Water, Saccharin Sodium.

### CLINICAL PHARMACOLOGY

Meperidine hydrochloride is a narcotic analgesic with multiple actions qualitatively similar to those of morphine; the most prominent of these involve the central nervous system and organs composed of smooth muscle. The principal actions of therapeutic value are analgesia and sedation.

There is some evidence which suggests that meperidine may produce less smooth muscle spasm, constipation, and depression of the cough reflex than equianalgesic doses of morphine. Meperidine, in 60 mg to 80 mg parenteral doses, is approximately equivalent in analgesic effect to 10 mg of morphine. The onset of action is slightly more rapid than with morphine, and the duration of action is slightly shorter. Meperidine is significantly less effective by the oral than by the parenteral route, but the exact ratio of oral to parenteral effectiveness is unknown.

### INDICATIONS AND USAGE

For the relief of moderate to severe pain (parenteral and oral forms)  
For preoperative medication (parenteral form only)  
For support of anesthesia (parenteral form only)  
For obstetrical analgesia (parenteral form only)

### CONTRAINDICATIONS

Hypersensitivity to meperidine.

Meperidine is contraindicated in patients who are receiving monoamine oxidase (MAO) inhibitors or those who have recently received such agents. Therapeutic doses of meperidine have occasionally precipitated unpredictable, severe, and occasionally fatal reactions in patients who have received such agents within 14 days. The mechanism of these reactions is unclear, but may be related to a preexisting hyperphenylalaninemia. Some have been characterized by coma, severe respiratory depression, cyanosis, and hypotension, and have resembled the syndrome of acute narcotic overdose. In other reactions the predominant manifestations have been hyperexcitability, convulsions, tachycardia, hyperpyrexia, and hypertension. Although it is not known that other narcotics are free of the risk of such reactions, virtually all of the reported reactions have occurred with meperidine. If a narcotic is needed in such patients, a sensitivity test should be performed in which repeated, small, incremental doses of morphine are administered over the course of several hours while the patient's condition and vital signs are under careful observation. (Intravenous hydrocortisone or prednisolone have been used to treat severe reactions, with the addition of intravenous chlorpromazine in those cases exhibiting hypertension and hyperpyrexia. The usefulness and safety of narcotic antagonists in the treatment of these reactions is unknown.)

Solutions of DEMOROL and barbiturates are chemically incompatible.

### WARNINGS

**Drug Dependence.** Meperidine can produce drug dependence of the morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of meperidine, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Like other narcotics, meperidine is subject to the provisions of the Federal narcotic laws.

**Interaction with Other Central Nervous System Depressants.** MEPERIDINE SHOULD BE USED WITH GREAT CAUTION AND IN REDUCED DOSAGE IN PATIENTS WHO ARE CONCURRENTLY RECEIVING OTHER NARCOTIC ANALGESICS, GENERAL ANESTHETICS, PHENOTHIAZINES, OTHER TRANQUILIZERS (SEE DOSAGE AND ADMINISTRATION), SEDATIVE-HYPNOTICS (INCLUDING BARBITURATES), TRICYCLIC ANTIDEPRESSANTS AND OTHER

CNS DEPRESSANTS (INCLUDING ALCOHOL). RESPIRATORY DEPRESSION, HYPOTENSION, AND PROFOUND SEDATION OR COMA MAY RESULT.

**Head Injury and Increased Intracranial Pressure.** The respiratory depressant effects of meperidine and its capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. In such patients, meperidine must be used with extreme caution and only if its use is deemed essential.

**Intravenous Use.** If necessary, meperidine may be given intravenously, but the injection should be given very slowly, preferably in the form of a diluted solution. Rapid intravenous injection of narcotic analgesics, including meperidine, increases the incidence of adverse reactions; severe respiratory depression, apnea, hypotension, peripheral circulatory collapse, and cardiac arrest have occurred. Meperidine should not be administered intravenously unless a narcotic antagonist and the facilities for assisted or controlled respiration are immediately available. When meperidine is given parenterally, especially intravenously, the patient should be lying down.

**Asthma and Other Respiratory Conditions.** Meperidine should be used with extreme caution in patients having an acute asthmatic attack, patients with chronic obstructive pulmonary disease or cor pulmonale, patients having a substantially decreased respiratory reserve, and patients with preexisting respiratory depression, hypoxia, or hypercapnia. In such patients, even usual therapeutic doses of narcotics may decrease respiratory drive while simultaneously increasing airway resistance to the point of apnea.

**Hypotensive Effect.** The administration of meperidine may result in severe hypotension in the postoperative patient or any individual whose ability to maintain blood pressure has been compromised by a depleted blood volume or the administration of drugs such as the phenothiazines or certain anesthetics.

**Usage in Ambulatory Patients.** Meperidine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient should be cautioned accordingly.

Meperidine, like other narcotics, may produce orthostatic hypotension in ambulatory patients.

**Usage in Pregnancy and Lactation.** Meperidine should not be used in pregnant women prior to the labor period, unless in the judgment of the physician the potential benefits outweigh the possible hazards, because safe use in pregnancy prior to labor has not been established relative to possible adverse effects on fetal development.

When used as an obstetrical analgesic, meperidine crosses the placental barrier and can produce depression of respiration and psychophysiological functions in the newborn. Resuscitation may be required (see section on OVERDOSAGE).

Meperidine appears in the milk of nursing mothers receiving the drug.

### PRECAUTIONS

As with all intramuscular preparations DEMEROL intramuscular injection should be injected well within the body of a large muscle.

**Supraventricular Tachycardias.** Meperidine should be used with caution in patients with atrial flutter and other supraventricular tachycardias because of a possible vagolytic action which may produce a significant increase in the ventricular response rate.

**Convulsions.** Meperidine may aggravate preexisting convulsions in patients with convulsive disorders. If dosage is escalated substantially above recommended levels because of tolerance development, convulsions may occur in individuals without a history of convulsive disorders.

**Acute Abdominal Conditions.** The administration of meperidine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special Risk Patients.** Meperidine should be given with caution and the initial dose should be reduced in certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

### ADVERSE REACTIONS

The major hazards of meperidine, as with other narcotic analgesics, are respiratory depression and, to a lesser degree, circulatory depression; respiratory arrest, shock, and cardiac arrest have occurred.

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea, vomiting, and sweating. These effects seem to be more prominent in ambulatory patients and in those who are not experiencing severe pain. In such individuals, lower doses are advisable. Some adverse reactions in ambulatory patients may be alleviated if the patient lies down.

Other adverse reactions include:

**Nervous System.** Euphoria, dysphoria, weakness, headache, agitation, tremor, uncoordinated muscle movements, severe convulsions, transient hallucinations and disorientation, visual disturbances. Inadvertent injection about a nerve trunk may result in sensory-motor paralysis which is usually, though not always, transitory.

**Gastrointestinal.** Dry mouth, constipation, biliary tract spasm.

**Cardiovascular.** Flushing of the face, tachycardia, bradycardia, palpitation, hypotension (see Warnings), syncope, phlebitis following intravenous injection.

**Genitourinary.** Urinary retention.

**Allergic.** Pruritus, urticaria, other skin rashes, wheal and flare over the vein with intravenous injection.

**Other.** Pain at injection site; local tissue irritation and induration following subcutaneous injection, particularly when repeated; anti-diuretic effect.

### DOSAGE AND ADMINISTRATION

#### For Relief of Pain

Dosage should be adjusted according to the severity of the pain and the response of the patient. While subcutaneous administration is suitable for occasional use, intramuscular administration is preferred when repeated doses are required. If intravenous administration is required, dosage should be decreased and the injection made

very slowly, preferably utilizing a diluted solution. Meperidine is effective orally than on parenteral administration. The dose of DEMEROL should be proportionately reduced (usually by 25 to 50 percent) when administered concomitantly with phenothiazines, many other tranquilizers since they potentiate the action of DEMEROL.

**Adults.** The usual dosage is 50 mg to 150 mg intramuscularly subcutaneously, or orally, every 3 or 4 hours as necessary.

**Children.** The usual dosage is 0.5 mg/lb to 0.8 mg/lb intramuscularly subcutaneously, or orally up to the adult dose, every 3 or 4 hours as necessary.

Each dose of the syrup should be taken in one-half glass of water since if taken undiluted, it may exert a slight topical anesthetic effect on mucous membranes.

#### For Preoperative Medication

**Adults.** The usual dosage is 50 mg to 100 mg intramuscularly subcutaneously, 30 to 90 minutes before the beginning of anesthesia.

**Children.** The usual dosage is 0.5 mg/lb to 1 mg/lb intramuscularly or subcutaneously up to the adult dose, 30 to 90 minutes before beginning of anesthesia.

#### For Support of Anesthesia

Repeated slow intravenous injections of fractional doses (eg, 1 mg/mL) or continuous intravenous infusion of a more dilute solution (eg, 1 mg/mL) should be used. The dose should be titrated to the needs of the patient and will depend on the premedication and the anesthesia being employed, the characteristics of the particular patient, and the nature and duration of the operative procedure.

#### For Obstetrical Analgesia

The usual dosage is 50 mg to 100 mg intramuscularly or subcutaneously when pain becomes regular, and may be repeated at 1-3-hour intervals.

### OVERDOSAGE

**Symptoms.** Serious overdosage with meperidine is characterized by respiratory depression (a decrease in respiratory rate and tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, particularly by the intravenous route, apnea, circulatory collapse, cardiac arrest, and death may occur.

**Treatment.** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonist, naloxone hydrochloride, is a specific antidote against respiratory depression which may result from overdosage or unusual sensitivity to narcotics, including meperidine. Therefore, an appropriate dose of this antagonist should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation.

An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression.

Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated.

In cases of overdosage with DEMEROL tablets, the stomach should be evacuated by emesis or gastric lavage.

**NOTE:** In an individual physically dependent on narcotics, the administration of the usual dose of a narcotic antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of narcotic antagonists in such individuals should be avoided if possible. If a narcotic antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care and only one-fifth to one-tenth the usual initial dose administered.

### HOW SUPPLIED

#### For Parenteral Use

**Detecto-Seal® — Carpuject® Sterile Cartridge-Needle Unit:** 2.5 percent (25 mg per 1 mL) NDC 0024-0324-02, 5 percent (50 mg per 1 mL) NDC 0024-0325-02, 7.5 percent (75 mg per 1 mL) NDC 0024-0326-02; and 10 percent (100 mg per 1 mL) NDC 0024-0328-02 all in boxes of 10.

Each cartridge is only partially filled based upon product volume to permit mixture with other sterile materials in accordance with best judgment of the physician.

**Uni-Amp® — 5 percent solution:** ampuls of 0.5 mL (25 mg) NDC 0024-0361-04, 1 mL (50 mg) NDC 0024-0362-04, 1½ mL (75 mg) NDC 0024-0363-04, and 2 mL (100 mg) NDC 0024-0364-04 in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) NDC 0024-0365-04 in boxes of 25.

**Uni-Nest™ — 5 percent solution:** ampuls of 0.5 mL (25 mg) NDC 0024-0371-04, 1 mL (50 mg) NDC 0024-0372-04, 1½ mL (75 mg) NDC 0024-0373-04, and 2 mL (100 mg) NDC 0024-0374-04 in boxes of 25; and 10 percent solution, ampuls of 1 mL (100 mg) NDC 0024-0375-04 in boxes of 25.

**Vials — 5 percent multiple-dose vials of 30 mL NDC 0024-0331-04 and 10 percent multiple-dose vials of 20 mL NDC 0024-0331-04 in boxes of 1.**

**Note:** The pH of DEMOROL solutions is adjusted between 3.5 and 6 with sodium hydroxide or hydrochloric acid. Multiple-dose vials contain metacresol 0.1 percent as preservative. No preservatives are added to the ampuls or CARPUJECT Sterile Cartridge-Needle Unit.

#### For Oral Use

**Tablets of 50 mg, bottles of 100 (NDC 0024-0335-04) and 500 (NDC 0024-0335-06); Hospital Blister Pak of 25 (NDC 0024-0337-06), 100 mg, bottles of 100 (NDC 0024-0337-04) and 500 (NDC 0024-0337-06); Hospital Blister Pak of 25 (NDC 0024-0337-02).**

**Syrup, nonalcoholic, banana-flavored 50 mg per 5 mL teaspoonful, bottles of 16 fl oz (NDC 0024-0332-06).**

Revised May 1988



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Division of Sterling Drug Inc.  
New York, NY 10016

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## Georgia Court Upholds Hospital Medical Staff Malpractice Insurance Requirement

Robert N. Berg

**A**T ANY HOSPITAL or other institutional health care provider, the provision of health care services is accomplished in large part by health care practitioners who are members of the facility's medical staff. Although a typical medical staff, as a self-governing organization, bears a significant responsibility for the quality of health care services rendered at the facility, it is the hospital itself — and, particularly, the governing body of the hospital — which bears the ultimate responsibility for the quality of care at the facility.<sup>1</sup> In furtherance of that responsibility, hospitals have been imposing more stringent criteria on physicians applying to obtain or retain medical staff membership and clinical privileges.

In a case of first impression in Georgia, the Court of Appeals recently was asked to assess the validity of one such requirement — that each member of the medical staff maintain a certain minimum designated amount of professional liability insurance coverage. The Court's opinion, upholding the validity of this requirement, is the subject of this month's Legal Page.

### Mandatory Professional Liability Coverage for All Medical Staff Members

In *Stein v. Tri-City Hospital Authority*,<sup>2</sup> the Court was faced with a situation involving a

resolution adopted by the Board of Trustees of the Tri-City Hospital Authority, d/b/a South Fulton Hospital (the "Hospital"), requiring that each member of the medical/dental staff at the Hospital carry at least \$1,000,000 in professional liability insurance coverage on and after a certain date. The resolution went on to provide that proof of the minimum malpractice insurance coverage would be required in conjunction with the medical staff appointment/reappointment process.

The Board of Trustees of the Hospital justified this action on a number of bases. First, the Board determined that the adoption of the minimum malpractice insurance requirement would protect patients of the Hospital from the financial insolvency of a negligent physician; malpractice insurance coverage would also serve to provide a fund from which patients who were injured by malpractice could recover. The Board also reasoned that the malpractice insurance requirement would save the Hospital money on its own coverage and thereby enable it to maintain a lower cost of care to patients. Finally, it was

determined that the requirement would protect other staff physicians and the Hospital against liability for the malpractice of an uninsured physician on the staff, as well as assure that if the Hospital were joined in a lawsuit against a staff physician, the physician would be able to contribute to the cost of defense.

In reaching its decision, the Board relied on an independent study undertaken by the Hospital as a development and planning strategy. It also determined that most physicians already had the minimum malpractice coverage in place or would have no difficulty in obtaining it, such that the requirement would not add significantly to the qualification process necessary to obtain or maintain staff privileges.

Following the implementation of the malpractice requirement by the Hospital, two physicians, including the plaintiff, Dr. Stein, had their medical staff membership and clinical privileges terminated, for lack of proof of compliance with the malpractice insurance requirement. The plaintiff then filed suit, contending that the Hospital's policy was invalid for a number of reasons, described below.<sup>3</sup>

### Hospital's Right to Adopt Reasonable Requirements

The plaintiff first contended that

This article was prepared at the request of the *Journal*. Mr. Berg is a principal in the law firm of Vincent, Chorey, Taylor & Feil, Suite 1700, The Lenox Building, 3399 Peachtree Rd., Atlanta, GA 30326. Send reprint requests to him.

the Hospital, by adopting the malpractice insurance requirement, improperly was delegating to its insurance company the duty to determine whether physicians applying for medical staff membership and clinical privileges were properly qualified to practice medicine. The Court summarily rejected this position, however, finding that the adoption of the requirement was in no way an unlawful delegation of authority to the insurance company. Rather, the Court viewed the restriction as "a rational and thoroughly debated decision unanimously made by the Hospital's Board of Trustees, with no apparent imput or pressure from the insurance company. . . ."<sup>4</sup> The plaintiff also contended that the Hospital had breached its "contract" with him, by eliminating his privileges with 1 year remaining in the agreed-upon term. This argument fared no better, however, as the Court refused to modify the well-settled principle that "a physician does not have 'absolute authority' to practice medicine in [Georgia] and a hospital authority may restrict a staff member's privileges by reasonable and non-discriminatory rules and regulations."<sup>5</sup>

Additionally, the plaintiff argued that the Hospital, by terminating his privileges, had violated his rights to due process. The Court flatly rejected this argument, finding both that the plaintiff did not have any protectable "liberty or property interest" in his privileges at the Hospital, and that the Hospital had acted reasonably under the circumstances in adopting the insurance requirement. Essentially, according to the Court, the plaintiff had accepted his medical staff privileges, subject to the

Hospital's Bylaws and those of the medical staff; the plaintiff should have recognized, assuming he had not done so, the ability of the Hospital and the medical staff to amend those bylaws, in order to provide rules and regulations for the governance and operation of the Hospital; and, that by failing to comply with reasonable rules and regulations promulgated by the Hospital and its medical staff, the plaintiff forfeited his right to medical staff membership and clinical privileges.<sup>6</sup> Accordingly, the Court, denying all of the plaintiff's claims, upheld the validity of the Hospital's malpractice insurance requirement.

**‘If a hospital and its governing body are to be held accountable for the quality of care rendered at the institution, then they should be provided with the leeway to adopt reasonable standards to assure the quality of those services.’**

#### Conclusion

No hospital has the completely unbridled right to restrict the membership of its medical staff through the enactment of unreasonable regulations. At the same time, as evidenced by the *Stein* case, a hospital may impose reasonable restrictions, enacted following a thorough evaluation of

the alternatives, with the expectation that the courts will not "second guess" the hospital as to the appropriateness of the regulations. If a hospital and its governing body are to be held accountable for the quality of care rendered at the institution, then they should be provided with the leeway to adopt reasonable standards to assure the quality of those services. That is the theory accepted by the courts in Georgia to date, and, we would anticipate, the theory that will continue to be applied in cases of this type in the future.

*[Decisions rendered by the Georgia Court of Appeals are subject to appeal to the Supreme Court of Georgia, which has the power to affirm or reverse the decision of the lower court, in whole or in part, with or without comment. Accordingly, it is possible that the opinion discussed in this article, although representing the current state of the law in Georgia, may be substantially altered or modified by the Supreme Court. Should this occur, we will inform you of that decision, once it is reached, in a subsequent issue of the Journal.]*

#### Notes

1. See, Rules and Regulations of the State of Georgia Department of Human Resources, Chapter 290-5-6.

2. \_\_\_\_\_ Ga. App. \_\_\_\_\_ (July 5, 1989), reprinted in *Fulton County Daily Report*, Vol. 100, No. 139, p. 6B (July 18, 1989).

3. *Id.*, \_\_\_\_\_ Ga. App. at \_\_\_\_\_.

4. *Id.*, \_\_\_\_\_ Ga. App. at \_\_\_\_\_.

5. *Id.*, \_\_\_\_\_ Ga. App. at \_\_\_\_\_.



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**Physician Opportunity** — PHP Healthcare Corporation, a leader in healthcare management services, has an immediate need for physicians to staff primary care clinics located in Columbus and Savannah. Other locations

include Fayetteville and Jacksonville, NC, Northern Virginia, Charleston, SC, and Jacksonville and Orlando, FL. Our company offers an outstanding incentive pay plan and provides paid malpractice insurance. PHP also offers a pleasant work environment free from on-call coverage with flexible scheduling arrangements. If interested, please call or send C.V. to: Leigh Robbins, PHP Healthcare Corp., 7044 Northridge Drive, Nashville, TN 37221, (615) 662-1310. EOE, m/f.

**Family Practice** — The Department of Family Medicine of the Medical College of Georgia is seeking a residency trained, board certified family physician with several years of practice experience to join the Department as a faculty member. Responsibilities will primarily include patient care activities and student and resident teaching. The position is at the assistant professor level and offers a unique opportunity to work with a young, progressive, active faculty and staff with unique resource support. Salary is competitive, with an unusually generous fringe

benefit package. Contact: William G. Caput, M.D., Vice-Chairman, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, (404) 721-2353.

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**STYLE** — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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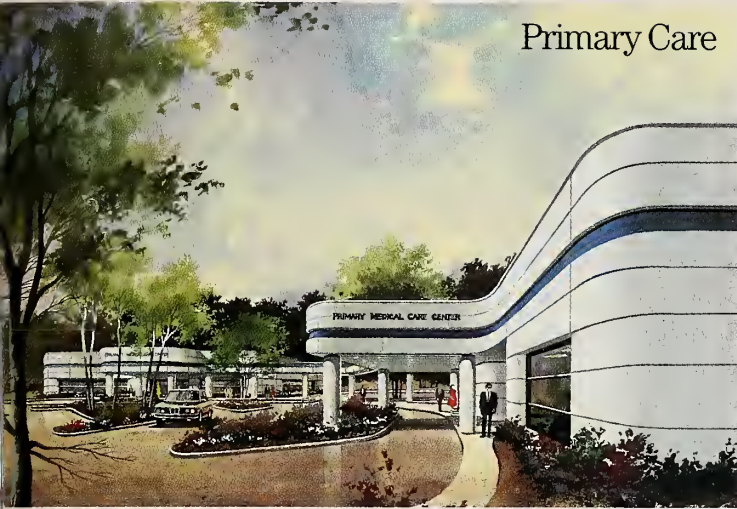
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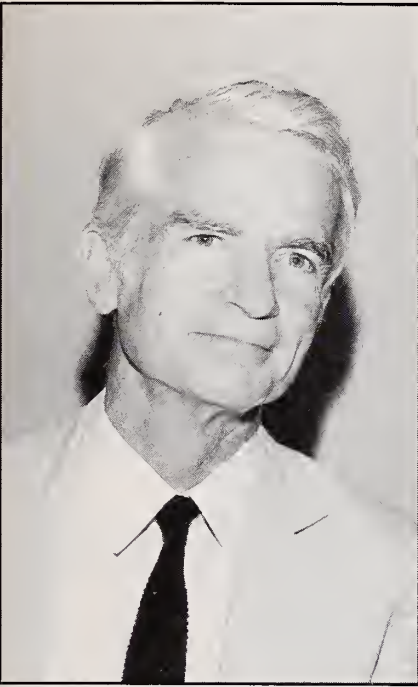


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**A**S OUR LOGO indicates, The Medical Association of Georgia was established in 1894. We are steeped in history and have a proud heritage. We now have almost 7000 members, a dedicated staff in a comfortable Headquarters office, and are united with a network of District and County Societies. However, every worthwhile organization, in order to remain effective, must periodically re-evaluate its purpose, goals, and methods.

In order to insure that we continue to provide the most effective care for the citizens of Georgia and represent the needs of the physicians of Georgia in this effort, we are in the process of developing some long-range plans.

MAG's Executive Committee is having special meetings with representatives from each district, past leaders, specialty societies, and young physicians to plan for the future. To that end, questionnaires have been sent to all MAG members to ascertain their individual professional needs and their ideas as to how

our organization can be more effective.

I am attempting to visit each area of the state, from the smaller societies of Habersham and St. John's Parrish to the larger societies of DeKalb and The Medical Association of Atlanta. Thank Goodness I have partners who support me in this effort and help me take care of my patients!

We are in a period of rapid change. We need to plan ahead and establish clear cut policies to help us deal with each crisis. Instead of spending all our time as firemen, stamping out fires, we must develop a climate that will prevent such crises.

The Medical Association of Georgia can only be as strong as its individual members. By filling out and returning the questionnaire you receive, by supporting your local medical society and attending its meetings, and by continuing to take care of our patients by practicing good medicine we can assure that the Medical Association of Georgia will properly fulfill its purpose.

## NEW MEMBERS

Bowman, Robert C., Family Practice — Ben Hill — (Active N2) 200 South Cherry St., Ocilla 31774

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Fletcher, Raymond R., Orthopaedic Surgery — Decatur-Seminole — (Active) 1502 East Evans St., P.O. Box 1867, Bainbridge 31717

Glaeser, Sally A., General Practice — Whitfield-Murray — (Active) 1103 Ridgeleigh, Dalton 30722

Gupta, Tarsem L., Internal Medicine/Pulmonary Medicine — Clayton-Fayette — (Active N2) 220 Buckeye Lane, Fayetteville 30214

Hubbuck, Sebastian O., Cardiology — Thomas Area — (Active) 114 Mimosa Dr., Thomasville 31792

Lawrence, John C., Pediatrics — Stephens-Rabun — (Active) Falls Rd. Prof. Pk., P.O. Box 1457, Toccoa 30577

Lee, Christopher M., Internal Medicine — Muscogee — (Service) 7201 Midnightsun Lane, Columbus 31909

Lonas, John R., Pediatrics — Decatur-Seminole — (Active N2) 1500 East Evans St., Bainbridge 31717

Merlin, Mark C., Anesthesiology — Douglas — (Active) 1311 Crestlane Dr., Smyrna 30080

Pennington, George P., General Surgery — South Georgia — (Active) 2724 North Oak St., Valdosta 31602

Poag, Joyce H., General Practice — Baldwin — (Active) 509 North Cobb St., Ste. 4, Milledgeville 31061

Ringer, Dave A., Family Practice — Oconee Valley — (Active N2) 1190 Siloam Rd., P.O. Box 470, Greensboro 30642

Shearin, W. Arthur, Jr., Anesthesiology — Newton-Rockdale — (Active N1) P.O. Box 80363, Conyers 30208

Watters, Leslie C., Pulmonary Medicine — MAA — (Active) 993 Johnson Ferry Rd., Ste. 210-D, Atlanta 30342

Webb, Robert S., Family Practice — Georgia Medical — (Resident) P.O. Box 23089, Savannah 31403

## PERSONALS

### *DeKalb Medical Society*

The DeKalb County Board of Health honored **Thomas Oscar Vinson, M.D.**, last October for his 26 years of service as DeKalb's chief public health officer.

At the ceremony, the Central Health Center in Decatur was renamed the Thomas Oscar Vinson Health Center. Dr. Paul Wiesner, the current health director; Manuel Maloof, chief executive officer of DeKalb County; and Dr. Benjamin Okel, former chairman of the State Board of Health Resources, were

among the dignitaries on the program.

Dr. Vinson assumed the position of director of health in 1950, where he remained until his retirement in 1976. A native of Byron, Georgia, he earned a medical degree from the Medical College of Georgia and a public health degree from John Hopkins University.

Under his leadership, DeKalb County established the first water fluoridation system in Georgia, as well as the first program to address mental health problems of preschool children. Dr. Vinson played a leading role in establishing a dental program for needy residents; setting up clinics for detection of cancer, tuberculosis, and other diseases, and beginning an environmental health program.

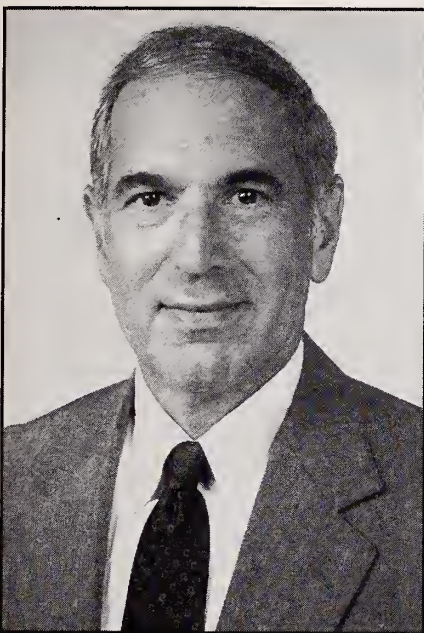
Considerable expansion and building occurred, including a new mental retardation evaluation and training center, 13 satellite health centers, and an alcohol treatment program that gained national recognition.

Dr. Vinson is past president of the Georgia Public Health Association, the Georgia Gerontology Society, and the Spalding County Medical Society. He was also an active member of the DeKalb Medical Society. Now 81, he resides at the Emory Woods retirement home.

### *Medical Association of Atlanta*

**Naomi Parver Alazraki, M.D.**, professor of radiology and co-director of Emory University's Nuclear Medicine Programs and chief of nuclear medicine at the Veterans Administration Medical Center in Atlanta, has been elected president of The Society of Nuclear Medicine. She will take office in June, 1990.





William E. Silver, M.D.

**William E. Silver, M.D.**, of Atlanta, was elected as the National Vice-President of the American Academy of Otolaryngology — Head & Neck Surgery at its annual meeting last September in New Orleans, Louisiana.

Dr. Silver has also been awarded a Preceptorship by the American Academy of Facial Plastic and Reconstructive Surgery where he will train one fellow per year in the area of facial plastic and reconstructive surgery.

*Whitfield-Murray CMS*

**James W. Marlow, M.D.**, a family practitioner in Dalton, has been named as a trustee of the Whitfield Healthcare Foundation. His 3-year term will begin July 1, 1990.

**Rudy McKey Shirley, M.D.**, of Dalton, has been named an associate graduate fellow of the American Academy of Facial Plastic and Reconstructive Surgery.

## OTHER NEWS

### *Kubler-Ross Coming To Atlanta*

**Elisabeth Kubler-Ross**, an internationally recognized author on death, dying, and transition, will make a special presentation in Atlanta on Friday, January 12, 1990. The program is one in a series of programs called the Good News Conspiracy, sponsored by the Metropolitan Atlanta Community Foundation and the Atlanta Church of Religious Science. The programs are designed to raise the consciousness of the community regarding nontraditional healing options for AIDS and other so-called "incurable" diseases.

The overriding theme of these programs is the healing integration of mind, body, and spirit.

Dr. Ross is the author of *On Death and Dying*, an international best-seller which is required reading in most major medical and nursing schools, graduate schools of psychiatry, and theological seminaries. She has also written nine other books including *AIDS: The Ultimate Challenge*.

The January 12 program is scheduled to be held at 8 p.m. at the offices of the Atlanta Church of Religious Science, 52 Executive Park Drive South, Suite Three, Atlanta. Tickets are \$25. For more information, call 636-4567.

## QUOTES

*The man of greatness never loses his child's heart.*

MENCIUS  
*Discourses, IV, c. 300 B.C.*

*Great men are not always wise.*  
JOB XXXII, 9, c. 325 B.C.

*Oh, that my tongue were in the thunder's mouth!  
Then with a passion would I shake the world.*

SHAKESPEARE:  
*King John III, c. 1596*

*We went to Mannheim and attended a shivaree — otherwise an opera — the one called "Lohengrin." The banging and slamming and booming and crashing were something beyond belief.*

S. C. CLEMENS (MARK TWAIN):  
*A Tramp Abroad, IX, 1879*

*One pain is lessen'd by another's anguish;  
One desperate grief cures with another's languish.*

SHAKESPEARE:  
*Romeo and Juliet, I, c. 1596*

*If all men defined "honorable" and "wise" alike there would be no debate on earth. As it is, each man defines these words for himself, and only the names remain unchanged.*

EURIPIDES:  
*The Phoenissæ, c. 410 B.C.*

*The first advice of a woman is always the best.*

FRENCH PROVERB

*In vain the sage, with retrospective eye,  
Would from th' apparent what conclude the why,  
Infer the motive from the deed, and show  
That what we chanced was what we meant to do.*

ALEXANDER POPE  
*Moral Essays, I (Of the Knowledge and Characters of Men), 1733*

# Physician's Recognition Award Recipients

**L**ISTED BELOW are those physicians in Georgia who have earned the AMA's Physician's Recognition Award (PRA) April through June, 1989.

The award was established by the AMA House of Delegates in 1968 "To recognize, encourage, and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a 3-year period to qualify for the Award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored for Category 1 credit by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Abreu, Vergil Richard, *Millen*  
Ackerman, Larry L., *Savannah*  
Alexander, Lee R., *Atlanta*  
Allen, Lawrence L., *Thomaston*  
Almeroth, Robert H., *Tucker*  
Anderson, Benjamin S.,  
*Cedartown*  
Andrews, Catherine S., *Kennesaw*  
Arora, Rajesh, *Augusta*  
Balog, Istvan, *Townsend*  
Barnard, Benj. Carson, *Vidalia*  
Bell, Victor C., *Fort Gordon*  
Beltran, Marilyn, *Monroe*  
Biddle, Michael Dean, *Griffin*  
Bishop, Jos. Arthur, *Calhoun*  
Broun, Paul Collins, *Americus*  
Bundy, Albert Thomas, *Atlanta*  
Carr, Clarence Dell, *Royston*

Chernecky, Richard E.,  
*Lawrenceville*  
Clayton, Robert Eugene,  
*Columbus*  
Cole, Craig Addison, *Hinesville*  
Courtney, Theresa Maureen,  
*Albany*  
Cox, Jon Paul, *Tucker*  
Davis, Henry G., *Sylvester*  
Davis, Lewis Marion, *Atlanta*  
Dewhurst, Timothy Andrew,  
*Decatur*  
Dover, Richard Kenneth,  
*Grovetown*  
Dulock, Malcolm Paul, *Norcross*  
Duttenhaver, John Raymond,  
*Savannah*  
Earle, Regina Margaret, *Columbus*  
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Fineman, Stanely Mark, *Marietta*  
Fishbein, Sumner Leon, *Augusta*  
Gallen, Jonathan Stewart, *Marietta*  
Garner, Cyler Duggan, *Gordon*  
Goolsby, Louis Wayne, *Cordele*  
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*Mountain*  
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## Preliminary Program Highlights

### SATURDAY, FEBRUARY 3

President Joe L. Nettles, M.D., Moderator

**M**orning Session — ETs, Mandatory Assignment & AEtna Bureaucracy: The Very Worst in Medicare Reimbursement

#### • Why Mandatory Assignment? A Debate

**Speaking for . . .** Vita Ostrander, Executive Director, Georgia Chapter, American Association of Retired Persons

**Speaking Against . . .** Joseph P. Bailey, Jr., M.D., Immediate Past President, MAG

We dodged a bullet last session of the General Assembly, but mandatory assignment will surely come up again next year. Vita Ostrander is a well-known spokesperson on the issue, both on state and federal levels. We hope Vita is on our side in the next Session, but for now we've got her

lined up against our own Dr. Bailey in a debate: "Why do we need mandatory assignment, anyway?"

#### • Georgia's Medicare Mess With AEtna

It's the hottest topic across the state: Why are Medicare reimbursements to Georgia physicians so backed up, and so often messed up? MAG's been working, negotiating and haranguing. We'll have an update.

#### • Fighting Medicare in Congress: ETs and the Threat of Rationed Care

Dr. Jim Todd, Senior Deputy EVP of the AMA, who has been on the front lines of the AMA's battles with Congress over reimbursement issues, will explain the latest on the "expenditure targets" which the government wants to thrust upon us. Dr. Todd has chosen as his title, "Fighting to

Save the Best of Medicine: or ET, Go Home!"

#### • What We're Doing in Georgia

We all know how Dr. Jeff Nugent of Atlanta has been boning up on Medicare issues and getting his MAG Public Relations Committee to work on informing older citizens of Medicare's pitfalls. He'll report on MAG's activities in this area.

#### **A**fternoon Session — Business, Government, and the NPDB: New Pressures for Change in Medicine

#### • The National Practitioner Data Bank: Your Rights Under the New PRO Reporting System

Heard of the NPDB? It's going to be an unpleasant fact of life for all of us in a few months, when the government gets underway its system for storing data for every physician in the country; liability lawsuits, PRO points, and the like. Who has access to this critical data? What safeguards do we have to ensure its accuracy? Mr. John Hanson, Director of the Data Bank in Washington, will tell us.

● **Where Is U.S. Medical Care Headed? A "Point-Counterpoint" on the Much Ballyhooed Canadian System of Health Care**

Many leaders of our society are talking seriously about bringing the Canadian system of government-financed health care to the United States. Why do they like it so much? And what arguments are being raised against it? We've lined up a debate on the subject, between a leading American proponent of the Canadian system, and an American physician who vigorously espouses private practice.

● **Physician Self Referrals: Ethics & Regulations**

Our friend Pete Stark in Congress wants to ban all physician's re-

errals to facilities in which they or a member of their family have made investments. AMA is leading the fight against this bill, pointing out how physicians help with these outside facilities to help patient care in wider areas. What are the ethical questions involved here, and what will the feds do to regulate genuinely abusive self-referrals? Janet Horan, AMA attorney who has been monitoring Stark's HR 939, will speak on this issue.

**SUNDAY, FEBRUARY 4**

**Two Optional Morning Workshops:**

**1) "Debates, Decisions & Delegates"**

Remember the excellent job Mary Lou Stephens and Julie vonHaam

did at the last Leadership Conference, teaching us the ins and outs of parliamentary procedure? Their seminar was so popular, we're going to hold it again on Sunday morning.

**2) "Tax & Investment Tips for the 90s"**

Sponsored by MAG Mutual Insurance Company

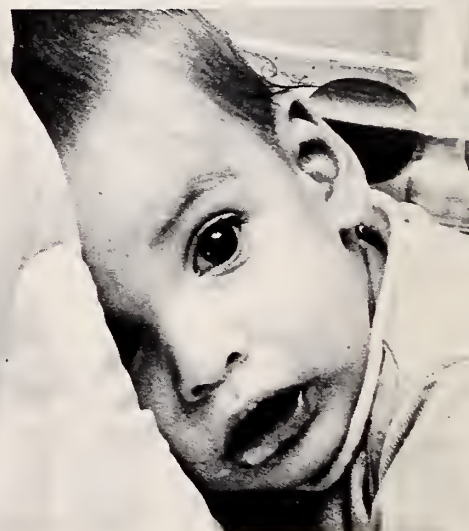
MAG Mutual's developed a new seminar to help physicians with your long-range planning. Company experts will discuss qualified retirement plans, welfare benefit trust, estate planning, business continuation agreements, and plenty of other important investment planning topics.

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## Hospitals and Their Employees Still Recovering from HUGO

Though Hurricane Hugo has passed, hospitals and their employees in South Carolina are still working their way out of the damage.

The South Carolina Hospital Association reports that a large number of hospital employees suffered great personal loss during the storm yet continued to keep their hospitals open. The association points out that many employees put on I.D. bracelets so their bodies could be identified after the storm. Acts of personal heroism were commonplace: a nurse who saved two children from being sucked out a window; two maintenance workers who tied themselves to the hospital, wading through waist-deep water and dodging flying debris to keep the emergency generator going; the nurses who kept a vigil over critical-care patients whose life-support alarms could not be heard over the wind; and the housekeepers who spent hours carrying buckets of water up and down the stairs to flush toilets.

To help those employees who suffered the greatest personal damage, the South Carolina Hospital Association has set up a Hospital Employee Relief Fund to provide what it describes as "modest financial help during this rebuilding phase." According to the association, money collected will go to the persons who have the greatest need, and SCHA will report on how much is collected and how it is used to help hospital employees in the state.

Contributions to the fund should be made to the Hospital Employee Relief Fund, South Carolina Hospital Association, P.O. Box 67009, West Columbia, SC 29171.

## Study Committee Winds Up Report on Health Care Shortage

The Joint Health Care Personnel Supply and Planning Study Committee was scheduled to meet in late October to finalize its report on the health care personnel shortage in Georgia.

The group, which was created by the 1989 General Assembly, is made up of legislators and representatives from all types of health care professions in the state. The chairperson is Rep. Eleanor Richardson (D) of Decatur.

During four meetings this year, the study committee has heard testimony from health care professionals from throughout Georgia detailing the difficulties they face as a result of the shortage of health care employees.

The committee earlier voted to develop a statewide data base to evaluate the manpower shortage in all health care professions. In addition, it agreed to establish a policy planning committee to study the data and make recommendations on how to solve the problem. The policy planning committee will then report to a legislative overview committee made up of members of the Georgia legislature who can, if needed, introduce legislation to help remedy the shortage.

According to GHA, the collection of data from all types of health care professions is necessary to create a total picture of the shortage in Georgia and to understand how it affects the delivery of health care. Currently, only piecemeal data are available from individual professions, and there is no way to see what is going on throughout the state.

Once the total data picture is in place, the policy planning

committee will be able to make specific recommendations, such as the creation of scholarships, programs to develop student interest in the health care professions, and funding for additional faculty positions in Georgia's colleges and universities.

The Joint Health Care Personnel Supply and Planning Study Committee is the outcome of efforts GHA began nearly 2 years ago. At that time, the association formed a Health Manpower Planning Committee to study ways to balance the supply and demand for health care professionals and to gather information on the personnel needs of all types of health care providers. At the request of the GHA committee, Rep. Richardson introduced a resolution to the Georgia legislature this year calling for the development of the committee.

## Medicare Support Letters Begin to Hit the White House

More than 4,000 letters had reached the White House in the first weeks of the American Hospital Association's "Promise to Protect Medicare" campaign.

Under the program, the AHA is calling for everyone connected with a hospital — physicians, employees, trustees, and auxiliaries — to write to President Bush asking him not to cut Medicare funding in the 1991 administration budget, which is scheduled to go to Congress in January.

Physicians who wish to write to the President should address letters to

President George Bush  
The White House  
1600 Pennsylvania Ave., NW  
Washington, DC 20500

The correct salutation is "Dear Mr. President."

*From BYNUM'S Scrapbook . . .*

## THE OLD COUNTRY DOCTOR

His face is seamed; his brows are shaggy,  
His coat is worn; his breeches baggy.  
But hope revives when he looks at you,  
With his kind old eyes of washed-out blue.  
Yonder he goes over the hills,  
With his saddle-bags and his bottles of pills.

The hearts of the country folk ride with him,  
And many eyes with tears grow dim,  
As they think of some far-off fateful night,  
When the grim old warrior won his fight.  
Yonder he goes over the hills,  
With the hearts of his folks and his bottles of pills.

He hasn't much time for churches or creeds,  
Too busy is he with his neighbor's needs,  
But he mutters a prayer to the Christ who died,  
As he watches all night at a cradle side.  
Yonder he goes over the hills,  
God bless the old Doc, with his bottles of pills.

The day is far spent; the hour is late,  
A tired old man is at Heaven's gate;  
"Come in," cries the King. The gate swings wide,  
"Come in Sir Knight of The Country Side!"  
He is traveling now the Heavenly Hills,  
And he carries a bottle of golden pills.

JAMES BOTHWELL MITCHELL

The above dedicated to the graduating classes in  
Medicine, Dentistry, Pharmacy, and Nursing —  
University of Tennessee, June 12, 1932.

*(Submitted by Richard Bynum Weeks, retired surgeon, Saint Simons Island.)*



## "Of Sadness And Jubilation — Of Hope And Friendship"

### A Study of Translations

*"The thief comes only to steal and kill and destroy. I have come so that they may have life and have it to the full."*

THE JERUSALEM BIBLE, JOHN 10:10

*"A thief comes only to steal and kill and destroy; I have come to let them have a life, and to let them have it in abundance."*

THE COMPLETE BIBLE — AN AMERICAN TRANSLATION, JOHN 10:10

*"A thief comes only to steal and kill and destroy; I have come that they may have life, and may have it in all its fullness."*

THE REVISED ENGLISH BIBLE, JOHN 10:10

*"The thief cometh not, but for to steal, and to kill, and to destroy: I am come that they might have life, and that they might have it more abundantly."*

THE KING JAMES VERSION, JOHN 10:10

*"The thief comes only to steal, to kill, to destroy; I have come that man may have life, and may have it in all its fullness."*

THE NEW ENGLISH BIBLE, JOHN 10:10

*"The thief's purpose is to steal, kill and destroy. My purpose is to give life in all its fullness."*

THE LIVING BIBLE, JOHN 10:10

**L**et us keep Christmas, its meaning never ends. Whatever doubts assail us, or what fears, let us hold close this day, remembering friends."  
ANONYMOUS

*"I sometimes think we expect too much of Christmas day. We try to crowd into it the long arrears of kindness and humanity of the whole year."*

DAVID GRAYSON

*"And if my nature wants the gum that grows towering to heaven like the mountain pine or like the oak sheltering multitudes I stand, not high it may be, but alone. Watching you other people making friends Everywhere, as a dog makes friends! I mark the manner of these canine courtesies and think: 'My friends are of a cleaner breed; Here comes — thank God — another enemy!'"*

ROSTAND

Cyrano de Bergerac

**C**HRISTMAS is difficult for my friend. Difficult and sad, and for some reason I must yet fathom, lonely. He becomes depressed. "How quite unusual," I say to him. "It's a happy time. Full of joy and singing and hope. Full of gift buying. Suffused with love for one another. The Christians are ecstatic that their Jesus has come to earth in the form of a baby. The Jewish folk are happy for the slow down in our frenetic pace of life and the chance for a week of sailing in the Caribbean. The others be they Muslim or atheist relish in the restful calmness of life. What is the matter with you?"

I say this to him, confident of the ground upon which I stand. I have such a strange way of seeing only one side of an issue. My side, of course. The tendency has created so much difficulty in my life.

But back to my friend. "You don't seem to understand," he says. "I've had so much trouble in my life. Problems with the children you have known about. The medical practice provided reasonable income, but problems with the partners took away a lot of the pleasure it should have provided. And could have. I love the patients, and they seem to love and need me. I miss them the most. But Christmas? My life has been so troublesome, so unfulfilling, that I find myself angry at you, at our friends, because of all your happiness. Your children have all done well. Your life has been so

undisturbed. Sometimes I simply hate you and your happiness."

**F**riendship is a puzzling thing to me. It seems to survive an inordinant amount of buffeting. Although on occasion deeply ingrained and held at high value, it fragments with bare stress. At other times, the ravages of the gods themselves dent not the rigid shell that guards and vouchsafes for it.

"Why do you attack me," I say to him. "I am your friend. We came through all of that together. You have been so difficult for me through the years that I wanted to just quit trying. You seem never to understand that I have problems, too. My children failed to scale the Everest I planned for them in my parental fantasy. My practice began in tragedy and survives in troubled waters. Are you really so different?"

We laughed. For many reasons. It's more practical. It requires fewer handkerchiefs. "Silent Night" floated out of the Public Broadcasting Station. "Christian music," he said. "Hopeful music," I said. "Hopeful not, perhaps, because it's Christian. Hopeful because it says something about you and me. About our wives and children. About our practice. About our friendship. Why bother that it's Christian? "Shalom," I said. "Slainte," he said. It kept playing, the radio in the child's bedroom. It was empty, the room. He was gone now. Grown up. "You've Come A Long Way Baby," it played as we stood there.

He put his arm about me. Hugged me. "I'm not sure about you," he said. "Are you Christian, Jewish, Muslim — are you an atheist or an agnostic? What in Heaven or Hell are you? Oh, forget it. Merry Christmas!"

CRU



## *Itinerant Surgery in the Guise of Outreach Surgery*

M. J. Jurkiewicz, M.D., F.A.C.S.

**“Unfortunately, the issue of itinerant surgery is confused by relating it to the distance from the surgeon’s office to the rural hospital. Even further, the economic problems of rural hospitals are being used to justify the practice.”**

RECENTLY, a guideline document intended to provide general advice to member hospitals of American Hospital Association (AHA) was published.<sup>1</sup> It was developed by the Division of Medical Affairs of the AHA “to assist member hospitals with outreach surgery programs to establish institutional protocols on credentialing and quality assurance.” The AHA further went on to say that “the practice of outreach surgery is controversial and is, in fact, opposed by the American College of Surgeons.”

Nowhere in College bylaws or principles is the term “outreach surgery” used, much less

opposed. The College, however, has been and remains opposed to “itinerant surgery.” The term outreach surgery is being used to obfuscate the central issue upon which the opposition of the College of Surgeons is based. Quality of care is compromised when critical elements of surgical care are delegated to an unqualified surrogate. The delegation of postoperative care clearly violates the basic responsibility of the surgeon.

Unfortunately, the issue of itinerant surgery is confused by relating it to the distance from the surgeon’s office to the rural hospital. Even further, the economic problems of rural hospitals are being used to justify the practice. The inconvenience of distance and the concern over income cannot be used to justify diminution of quality care. It is clearly feasible for conscientious surgeons to travel the same distance to provide for the direct supervision of postoperative care on a daily basis as was travelled to perform the operation.

The American College of Surgeons when founded in 1913 was organized to improve not only the standards of surgical practice in the country but also the standards of care in hospitals. With its founding, elected officials of the College established the Committee on Hospital

Accreditation to inspect and accredit hospitals. From 1916 until 1952, when the College spearheaded the move to establish the Joint Commission on the Accreditation of Hospitals, the Fellows of the College, out of their dues, paid for this hospital inspection and accreditation program. The hospitals themselves paid nothing! The College is one of the parents of the Joint Commission on the Accreditation of Health Care Organizations along with the American College of Physicians, the American Medical

**“Nowhere in the ACS bylaws or principles is the term “outreach surgery” used, much less opposed. The College, however, has been and remains opposed to “itinerant surgery.”**

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Association, the American Dental Association, and the American Hospital Association.

The American College of Surgeons firmly believes that optimal achievable surgical care is provided by surgeons trained in hospital programs approved by the Accreditation Council for Graduate Medical Education and certified by surgical specialty boards recognized by the American Board of Medical Specialties. Surgical care includes preoperative evaluation, diagnosis, and treatment; intraoperative and postoperative care.

**‘The Office of the Inspector General found that 65% of the sampled itinerant surgeons billed global fees but did not provide global care, e.g., pre-and postoperative care as well as performing the operation itself.’**

Why pre- and postoperative care? Why not delegate, as suggested by AHA and the American Academy of Family Practice? Only fully trained surgeons understand completely the nuances of diagnosis of surgical conditions, indications for operative intervention, risks of the procedure. That is what they are trained and educated to do. Most importantly, postoperative complications not infrequently are

difficult to recognize early and often require prompt surgical intervention. Thus, quality of care to the patient is central to the position of the College. In addition, the practice of itinerant surgery is pernicious because it is rooted in fee-splitting.

**T**he most recent verification of the concerns of the American College of Surgeons comes from a report from the Office of the Inspector General (OIG), Richard Kusserow, to William L. Roper, M.D., former Administrator of the Health Care Financing Administration (HCFA). The OIG conducted a study in 1988 to determine not only the extent to which rural hospitals use itinerant surgeons but also the potential impact of itinerant surgery on the quality of care and billing practices.<sup>2</sup> Twenty-eight percent of the small rural hospitals (under 50 beds) sampled used itinerant surgeons who performed 73% of the operations in such hospitals. By an independent peer review mechanism, poor quality of care was found in 26.6% of the itinerant surgery cases reviewed — significantly higher than the 3.3% rate of poor quality care found in a related population of patients cared for in small rural hospitals (National DRG Validation Study). The OIG also found that 65% of the sampled itinerant surgeons billed global fees but did not provide global care, e.g., pre- and postoperative care as well as performing the operation itself. The referring physician billed for such care. This practice of double billing clearly drives up the cost of care and drives down the quality of care. The OIG recommended that administrators and physicians in rural hospitals take appropriate

steps to insure adequate preoperative work up, urged second opinion, postoperative plans of care, and postoperative communication between the attending physician and the itinerant surgeon. In addition, the OIG recommended that HCFA take steps to eliminate overpayment in cases where itinerant surgeons provided surgery only. These recommendations clearly address symptoms, not etiology or cause. This indirect approach to the problem also characterizes the AHA recommendations which stipulate that the itinerant surgeon should be included in the preoperative assessment process and the decision to operate. However, the AHA further recommends that the physician responsible for the postoperative care “be able to treat routine postoperative complications and be experienced in distinguishing which medical and surgical complications require transfer.”

Why not approach the problem directly? Surgeons should take care of surgical patients. Preoperative care, the decision to operate, the postoperative care has to be the responsibility of the attending surgeon. The College is not against surgeons treating patients in rural hospitals. The College insists, however, that the surgeon must provide the preoperative assessment, the operative care, and the postoperative care. These essential components of surgical care cannot be delegated to an unqualified surrogate.

## References

1. Credentialing of Outreach Surgeons. American Hospital Association Guidelines, August, 1988.
2. OIG Draft Report. Itinerant Surgery. November, 1988.



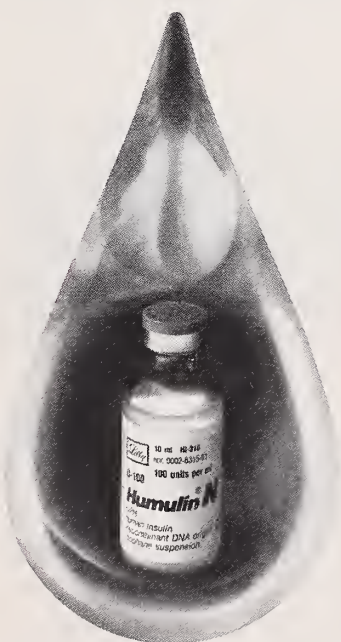
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12-13 — *Atlanta: Medical Management of Repetitive Motion and Low Back Injuries.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-20 — *Atlanta: Retina-Vitreous Seminar.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-Feb. 2 — *Atlanta: Introduction to Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

## FEBRUARY 1990

2-3 — *Atlanta: 27th Annual Emory-Grady Alumni Postgraduate Conference: Ophthalmology 1990.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

3-10 — *Park City, Utah: Acute Illness and Injuries.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

5-9 — *Atlanta: Introduction to Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10 — *Atlanta: Ethical Decision Making in Medicine.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

10-17 — *Breckenridge, CO: New Horizons in Anesthesiology.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

19-23 — *Atlanta: Introduction to Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

23-24 — *Augusta: Flexible Fiberoptic Sigmoidoscopy.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

## MARCH 1990

3-10 — *Steamboat Springs, CO: 15th Annual Snow Job in Gynecology and Obstetrics.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-9 — *Atlanta: Introduction to Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

5-10 — *Augusta: 25th Annual Family Practice Symposium.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

9-10 — *Augusta: Ophthalmology.* Category 1 credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

16 — *Macon: Cancer Management Update 1990.* AMA Category 1 credits and AAFP prescribed credits. Contact Robert Fore, Ed.D., Medical Center of Central Georgia, 777 Hemlock Street, Macon 31201. PH: 912/744-1634.

23 — *Atlanta: Perspective in Parenteral/Enteral Nutrition — 12th Annual Metabolic Support Service Seminar.* Category 1 credit. Contact Jean Robinson, Pharm.D., Metabolic Support Service, Georgia Baptist Medical Center, 300 Boulevard, Box 235, Atlanta 30312. PH: 404/653-4499.

26-30 — *Atlanta: Introduction to Magnetic Resonance Imaging.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-30 — *Atlanta: Management Problems of Anesthesia & Life Support in the Cardiac Surgery Patient.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

29-31 — *Hilton Head Island, SC: Frontiers in Nutrition.* Category credit. Contact Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/721-3967.

30-31 — *Atlanta: Expert Testimony.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.

31-April 1 — *Atlanta: Pharmacology for the Anesthesiologist.* Category 1 credit. Contact Office of CME, Emory Univ. Sch. of Med., 1440 Clifton Rd., Atlanta 30322. PH: 404/727-5695.



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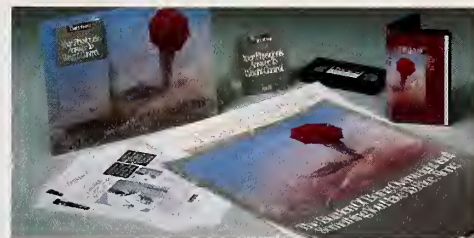
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# The True Symbol of Medicine: One Snake or Two?

Lou Carver

**T**HE CADUCEUS, a winged rod entwined with two serpents, has long been regarded as the universal symbol of medicine. And yet there is also the Aesculapian staff, a single snake entwined around the knotty staff of Aesculapius, the Roman god of medicine and healing (the Greek Asklepios). Which is the true symbol of medicine?

More than 70 years ago, the AMA House of Delegates adopted the Aesculapian staff as America's medical emblem. In 1956, during the 10th Annual Meeting of the World Medical Association held in Havana, Cuba, this same staff was internationalized as the symbol of medicine.

## **Caduceus or Staff of Aesculapius?**

Both symbols contain the snake, a creature whose ability to shed its skin and start life anew easily expressed the mystical imagination of ancient man. From India to Egypt, the snake motif was used as a magical creature, a force of both good and evil.

According to legend, the Roman god Mercury (the Greek Hermes) was given a wand to carry by Apollo.

Ms. Carver is the managing editor of Medical Bulletin, the quarterly publication of the Spokane County Medical Society, Spokane, Washington. This article is reprinted in part from the Fall 1987 issue of that publication.



(The word caduceus is a Latin adaptation meaning "herald's wand.") In the beginning, Mercury was portrayed with his wand and winged traveling-hat and shoes for speed.

Around 350 B.C., Mercury's wand appears with two snakes entwined and wings attached. As the story is told, Mercury had come upon two serpents fighting and separated them with his wand. The serpents were so grateful they climbed up the wand entwined in gratitude.

Mercury was not only known as a shrewd messenger for the gods but also as the patron of merchants, travelers, and thieves, as well as the god of exercise, games, and luck. In medicine, he was known for averting plagues, assisting in childbirth, healing with plants, virility, and sanity. With all these attributes to one god, restricting Mercury to one major area is impossible.

**H**ow did the Roman Aesculapius become connected to the medical symbol? Born the son of Apollo, Aesculapius was raised by a centaur (half man, half horse) named Chiron. He was skilled in medicine and taught Aesculapius everything he knew. All the legends that can be traced relate Aesculapius exclusively to medicine.

Aesculapius carried the reputation for supernatural healing powers. His god-like status was derived from the Greek belief that people who survived an illness were being resurrected from the dead.

While visiting a patient, a snake coiled itself around his staff. He killed the snake and then another appeared with a herb-leaf in its mouth which restored the dead snake to life.

By around 200 B.C., over 200 temples in Greece had been dedicated to Aesculapius. They were generally constructed in grove-like areas, with the sacred serpents responsible for the selection of their locations. Snakes were allowed to roam free throughout all the temples. The main shrine was located at Epidaurus. It was thought that sleeping in the temple would bring

about a cure. The method of treatment was known as "incubation sleep." During sleep, the gods would manifest themselves into serpents, which visited the patients and licked their diseased body parts.

In the *Iliad*, Aesculapius' two sons were mentioned as "physician-warriors." In the 3rd century B.C., Athenian coins bear Aesculapius head on one side and a serpent on the other. Most surprising, Hippocrates is registered as the 18th descendant from the one son of Aesculapius.

Mercury carried a wand with two snakes, and Aesculapius carried a staff with one. Both had direct connections to Apollo and were synonymous with healing. It is easy to see how significant confusion occurred in symbolism.

### Current Symbol Recognition

During the 1500s, both symbols seemed to have been used to portray medicine. Pharmacy, chemistry, and medicine were not clearly defined yet. Several printers took the liberty of using the caduceus as the trademark symbol for first printings of medical works. However, around the latter part of the 1600s medical medals and calling cards began to feature the Staff of Aesculapius.

The most demanding use of the medical symbol is related to military use. French medicine, whether military or civilian, has always used the Staff of Aesculapius. In 1868, the German military adopted it as their medical symbol, while shortly afterward the Royal Army Medical Corps of England followed suit. In all of Europe, the sole medical military use of the caduceus is the Royal Air Force.

In 1902, the U.S. Army Medical Department established the caduceus as their coat of arms; the Navy followed. However, the Air Force has chosen the Aesculapius Staff. It seems strange that U.S. Army medicine has chosen the caduceus, even though Mercury was not a physician.

The Aesculapius Staff has more of an acceptance on a world-wide basis than in our country. ■



# Massive Orbital and Intracranial Teratoma in the Newborn: A Case Report

Ran Neiger, M.D., Linda M. Sacks, M.D.

## Case Report

**A**N 18-YEAR-OLD primigravida with an uncomplicated prenatal course was admitted to a level I hospital at 36 weeks gestation with ruptured membranes and vertex presentation. Because of failed pitocin induction, an ultrasound examination was obtained, revealing the presence of hydrocephalus and an additional facial lesion initially thought to be a cystic hygroma. The patient was referred to our tertiary care institution. Repeat ultrasound evaluation confirmed hydrocephalus as well as the presence of a large cranial and facial mass. The patient underwent a primary cesarean section.

The 3.0 kg male infant had an obvious left orbital mass and severe hydrocephalus. The baby had no spontaneous respirations and was immediately intubated. Apgar scores were three and four at 1 and

## Abstract

**Severe hydrocephalus secondary to a massive teratoma occupying the left lateral ventricle and protruding from the left orbit was diagnosed in a newborn infant. A craniofacial mass had been initially detected during labor by ultrasound examination. The pathophysiology of teratomas and the clinical course and ethical issues in management of this child are discussed.**

5 minutes, respectively. Head circumference was 43 cm, well above the 95th percentile. The left side of the face was distorted by a spherical mass, 10 cm in diameter, protruding from the left socket underlying the remnant of the globe (Figure 1). The tumor was predominantly solid to palpation. There

were no cutaneous lesions, and no other anomalies were noted.

Extensive evaluation by a neonatologist, neurosurgeon, neurologist, ophthalmologist, and radiologist concluded that the

tumor involved the entire left cerebral hemisphere and orbit. The left lateral ventricle was obliterated. Obstructive hydrocephalus with marked enlargement of the right lateral ventricle and massive shift of the midline structures to the right were present on CT scan (Figure 2). Skull films revealed a non-displaced, presumably pathologic fracture in the midportion of the left superior parietal bone. Respiratory compromise was attributed to brain stem compression.

The presumptive diagnosis was teratoma, possibly malignant, and certainly inoperable. The dilemma of postponing the infant's inevitable death by means of mechani-

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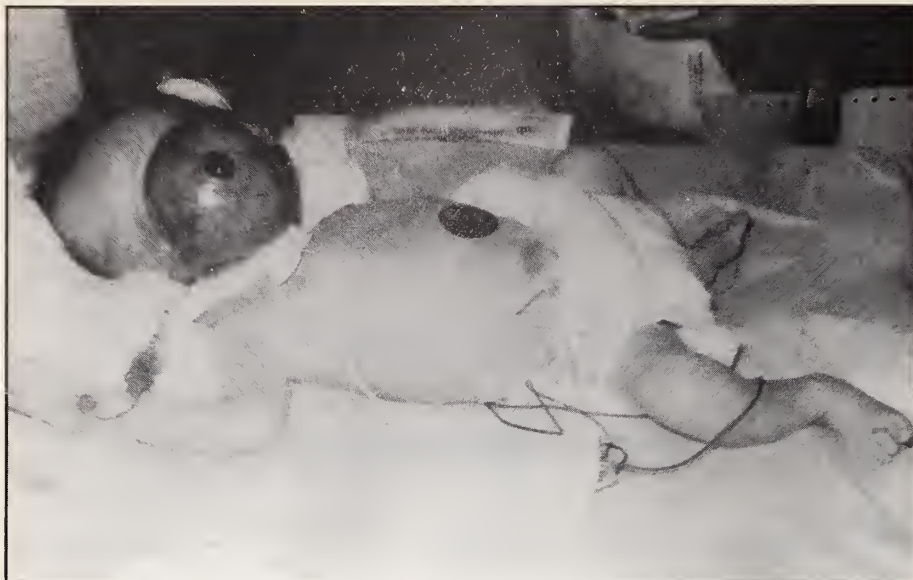


Figure 1: Teratoma measured 10 cm in diameter. Remnant of globe is seen atop the tumor.

cal ventilation versus withdrawal of artificial means of support was carefully explained to the family in a non-judgmental manner. The possibility of discontinuation of heroic support measures was offered. It was explained that even if the ventilator were discontinued, all other care would remain the same, except for efforts at resuscitation. The possibility that the infant might survive even after withdrawal of mechanical ventilation was also discussed. The family was offered the opportunity to obtain a "second opinion" at another tertiary care facility. The child's poor prognosis for life and neurologic development, with or without surgery, and the likelihood of multiple craniofacial and neurosurgical procedures was presented.

At the end of the second day of life, the parents, with full support of their families, attending physicians, and baby's primary nurses, elected to discontinue the respirator. Oxygen therapy, intravenous fluids, and nursing care under a radiant warmer were continued. Family members took turns holding the baby until he died several hours later.

**A**utopsy confirmed the presence of a large teratoma arising from the orbit, extending into the optic tunnel and lateral ventricle. Microscopic sections showed background of embryonic type tissue with islands of cartilage, bone, nerves, glandular and ciliated columnar epithelium. The histology

was well differentiated, and the tumor compressed rather than invaded adjacent tissue. Chromosomal analysis of peripheral blood leukocytes was normal.

A telephone conference was held with the parents several weeks after the child's death. The purpose of this call was to reaffirm the appropriateness of the family's decision, to explain autopsy findings, and to explore the family's grieving process. This type of death consultation is offered to all parents and is normally held in the physician's office, but distance prevented the parents from coming to the hospital. Five months after the baby's death, a let-

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**The modern neonatal intensive care unit is replete with the technology to prolong life indefinitely, even at a near-vegetative level. The futility and immorality of such action in the eyes of many physicians, ethicists, and parents was highlighted in the recent struggle over the so-called "Baby Doe" legislation.**

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ter thanking our staff for the care and support given them and their child was received.

### Discussion

Teratomas are tumors arising from gonadal and germ cell origin. More than 50% of all teratomas are sacrococcygeal, although they occur commonly in the gonads as well.<sup>1</sup> When growing in extra gonadal sites they represent aberrations in the migration of germ cells from the yoke sac into the developing fetus. They are uncommon in infancy, occurring at the rate of 1 per 14,000 live births.<sup>2</sup> The age incidence initially peaks below the age of 2 years, and half of these early cases are diagnosed during the first month of life.<sup>1</sup> The second peak incidence occurs after the age of 6 in females (ovarian) and after the age of 14 in males (testicular).<sup>1</sup> Teratomas contain elements derived from all three embryonic germ layers. Benign teratomas have been described in many organ systems including facial and intracranial teratomas. When occurring as masses in unusual body loci, these congenital tumors can present a diagnostic problem and may sometimes necessitate emergency treatment.<sup>3-5</sup> Successful surgical resection of the tumor depends on the site and involvement of critical structures.<sup>1, 6, 7</sup>

The case presented here was not a diagnostic dilemma. Rather, the difficulty lay in choosing appropriate management of this severely affected newborn. The modern neonatal intensive care unit is replete with the technology to prolong life indefinitely, even at a near-vegetative level. The futility and immorality of such action in the eyes of many physicians, ethicists, and parents was highlighted in the recent struggle over the so-called "Baby Doe" legislation.<sup>8</sup> The federal government attempted via legislation to assure equal treatment under the law for all handicapped newborns. Many pediatricians believed the ruling compelled them to forcibly keep alive infants so severely damaged that they could not be expected to become participants in society even



if they survived.<sup>9, 10</sup> Nullification of 1983 "Baby Doe" legislation by the United States Supreme Court returned responsibility for decision making for children for whom life-saving therapies are available but for whom the ultimate long-term benefit to the infant of such therapy is questionable to parents and physicians.<sup>11, 12</sup>

**W**hereas the adult's right to refuse life-saving treatment is rooted in the principle of self-determination and the constitutional right to privacy, life-and-death decisions regarding infants are based on the "best interests" of the child. In some circumstances, it is possible that the best interests of a multihandicapped child is a dignified death, rather than prolonged life in an intensive care environment.<sup>13</sup> In addition, the courts have ruled that in cases where it is impossible to determine the patient's wishes (such as a newborn), a legal solution may be a pure objective test: support can be withdrawn where the burden of life clearly and markedly outweighs its benefits, and the patient suffers from such severe and unavoidable pain that continuing to treat is inhumane.<sup>13, 14</sup> Although in this case both child's physicians and parents concurred in the decision to withdraw life support, there are instances when parent-physician or interphysician disagreement as to the best course of treatment (or non-treatment) of terminally ill infants exists. In such cases, a hospital bioethics committee can be of great assistance, although its decisions are not legally binding.<sup>16</sup> Only in unusual cases it is necessary to resort to the courts.<sup>17</sup>

The decision to terminate life support or not to institute "heroic measures" on behalf of a patient is *not* a decision to abandon the infant or his family. It is critical to the physician-parent relationship, and for the parents emotional well-being, that it not be interpreted as such. A plan of continued care for the baby must be outlined as part of the decision, regardless of whether life support systems are

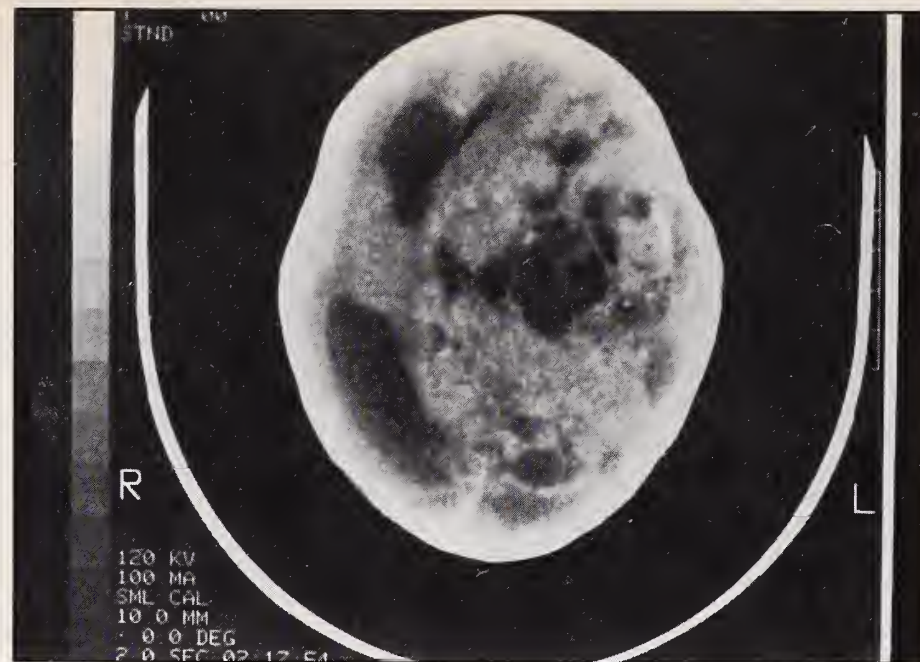


Figure 2: CAT scan obtained at 8 hours of age shows intra- and extracranial tumor mass with destruction of entire left hemisphere and most of right hemisphere.

continued or terminated. The professional staff, including the physicians, must be committed to continued emotional support for the family, regardless of the decision.

### Summary

In the present case of a neonate with a life-threatening, inoperable, craniofacial tumor, a multidisciplinary team of attending physicians, after careful evaluation, presented the situation to the newborn's family. Management alternatives and the prognosis of the infant were discussed, and the option of a "second opinion" in another institution was offered. The possibility of discontinuation of heroic life support measures was brought up by the physicians. The ventilator, in the absence of a plan for surgical treatment, was presented as the instrument of prolonging dying, rather than of prolonging or saving life. When the parents elected to discontinue mechanical ventilation, continued support in the form of oxygen, intravenous fluids, environmental temperature control, and skilled nursing care was provided. These modalities were viewed as not postponing inevitable death but providing comfort to the patient. Emotional support for the family during this period was provided by nursing staff and attending physicians. This action allowed a natural death with no additional prolonged suffering for the baby.

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# MRI UPDATE

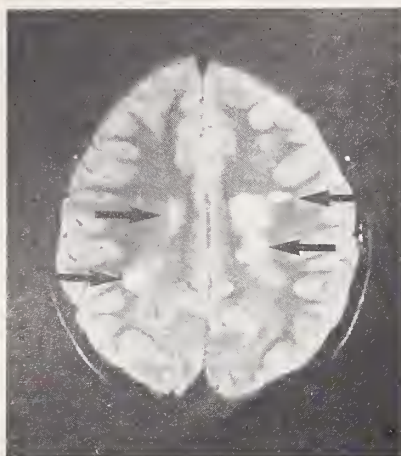


Figure 1

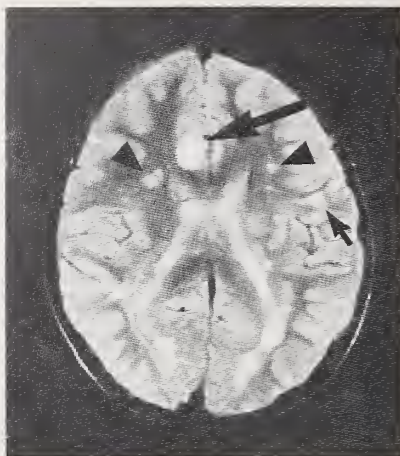


Figure 2



Figure 3

## CLINICAL INFORMATION:

Recently, there has been much discussion in the literature of the neurological symptoms caused by the spirochete *Borrelia burgdorferi*. The disease is transmitted by a tick bite and is associated with clinical symptoms of headaches, multiple arthralgias, and non-specific neurological symptoms. Given the appropriate clinical history, a diagnosis of Lyme disease can readily be confirmed by an MR scan.

**FINDINGS:** Figure 1 is a T2-weighted axial image through the brain. Abnormal focal areas of increased signal intensity can be identified within the centrum semiovale bilaterally (small arrows). These lesions are primarily located within the white matter but are of differing sizes. Figure 2 is also an axial image through the brain but at a level through the lateral ventricles. This section shows a

lesion located within the medial gray matter of the right frontal lobe anterior to the corpus callosum (large arrow). Additional areas of abnormal increased signal intensity can be identified adjacent to the occipital horns, in the gray-white matter interface of the left parietal operculum (small arrow), and in the deep white matter of the frontal lobes in the region of the anterior corona radiata (arrowheads). Figure 3 is through the posterior fossa as well as the lower frontal and temporal lobes. Abnormal areas of increased signal intensity are demonstrated in the left anterior pons (large arrow) in the anterior right temporal lobe (small arrow), in the right cerebellar peduncle (arrowhead), and in the medial right temporal lobe (curved arrow).

The MR images clearly demonstrate the predominantly white matter involvement, multifocal nature, and the absence of

mass effect associated with these lesions. In the absence of clinical history, the MR appearance would be most consistent with a demyelinating process such as multiple sclerosis. However, as this case presented in a nine year old male following exposure to ticks, the differential diagnosis becomes that of Lyme disease. The diagnosis was further confirmed by the findings of similar, although less extensive lesions, in the patient's sibling.

**COMMENT:** The patient in the case above had a CT scan prior to the MR study which was negative. This case clearly demonstrates the increased sensitivity of MR over CT in detection of white matter processes. However, the case also demonstrates the relative non-specificity of the findings. In this case, the clinical history was most important in determining the true etiology of the patient's findings.



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# Antiphospholipid Antibodies in Stroke

David C. Hess, M.D., Robert J. Adams, M.D., Fenwick T. Nichols, M.D.

**S**TROKE REMAINS the third leading cause of mortality in the United States. Despite greater awareness of the role of cardiac embolism in stroke and technologic advances to help determine etiologies, 24% of ischemic cerebral infarctions remain of unknown cause.<sup>1</sup> A promising new avenue of research is the investigation into the role of antiphospholipid antibodies and hypercoagulability in stroke. This represents a newly discovered immunologically mediated cause of stroke.

## Background

Antiphospholipid antibodies are circulating immunoglobins usually of the IgG or IgM class, but occasionally IgA, directed at negatively charged phospholipids.<sup>2</sup> At the present time, they are detected by one of three clinical tests: rapid plasma reagin (RPR), lupus anticoagulant, and anticardiolipin assay.<sup>3</sup> These tests measure overlapping populations of immunoglobulins with closely related antigenic specificities. The concordance rate between the anticar-

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**A promising new avenue of research is investigating the role of antiphospholipid antibodies and hypercoagulability in stroke. This represents a newly discovered immunologically mediated cause of stroke.**

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diolipin assay and lupus anticoagulant is 65%, and between these and the RPR 25%.<sup>4</sup>

The least sensitive indicator of antiphospholipid antibodies is the RPR. A variety of tests have been developed to detect reagin, or the nonspecific treponema antibody,

beginning with the Wasserman test in 1906 and later the VDRL.<sup>5</sup> It has been established that the antigen bound by reagin is an acidic phospholipid, obtained by alcohol extraction of ox heart muscle.<sup>6</sup> This has been named cardiolipin.

During widespread screening of both military and nonmilitary populations during World War II, it became evident that a number of people had positive tests for syphilis without any clinical evidence of disease.<sup>7</sup> With the development of a specific test for treponema pallidum in 1949, the treponemal immobilization test, it became clear that these were false-positive reagin tests.<sup>7</sup> In a study of these false-positive reactors, it was found that there were two groups.<sup>8</sup> The first had transient false-positive tests and generally had intercurrent infection. The second group had chronic false-positive tests and usually had autoimmune disease, such as systemic lupus erythematosus (SLE), hemolytic anemia, and rheumatoid arthritis.<sup>8</sup> These patients often had positive ANA tests, and some had thrombosis.

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The link between false-positive syphilis tests and the lupus anticoagulant was made by Conley and Hartmann<sup>9</sup> in the first description of a circulating anticoagulant in SLE. Originally described in SLE, the lupus anticoagulant has subsequently been found in association with drugs (notably chlorpromazine<sup>10</sup>), the puerperium,<sup>11</sup> other autoimmune diseases,<sup>12</sup> neoplasia,<sup>13</sup> HIV infection,<sup>14</sup> and other infections.<sup>15</sup> It is an antibody directed against the phospholipid component of the prothrombin activator complex.<sup>16</sup> Consequently, it interferes with all phospholipid dependent coagulation tests. While "in vitro" it behaves as an anticoagulant and can prolong the standard activated partial thromboplastin time (PTT) and prothrombin time (PT); "in vivo," paradoxically, it is associated with hypercoagulability.<sup>17, 18</sup> In patients with SLE, it has been found to be a marker of the subset of patients with thrombotic events.<sup>19</sup>

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**In the past 5 years, a particularly strong link has been found between the lupus anticoagulant and cerebrovascular disease in both SLE and non-SLE patients.**

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These include peripheral deep vein thrombosis,<sup>19</sup> superficial vein thrombosis,<sup>20</sup> axillary and subclavian thrombosis,<sup>18</sup> Budd Chiari Syndrome,<sup>21</sup> mesenteric vein and artery thrombosis,<sup>22</sup> myocardial infarction,<sup>20</sup> and cerebral ischemia.<sup>22</sup> Of patients with a lupus anticoagulant, 94% will have a prolonged PTT, and 33% a prolonged PT.<sup>23</sup> In order to differentiate a prolonged PT secondary to a coagulation factor deficiency from that secondary to an anticoagulant, a 1:1 mix of the pa-

tient's plasma is performed with normal plasma. A failure of the PTT to correct is presumptive evidence of an anticoagulant.<sup>17, 18, 23</sup> More specific tests to determine whether this is a lupus anticoagulant or another type of anticoagulant (such as factor VIII antibodies in hemophiliacs) include the tissue thromboplastin inhibition test and platelet neutralization tests.<sup>23</sup>

### Clinical Features

In the past 5 years, a particularly strong link has been found between the lupus anticoagulant and cerebrovascular disease in both SLE and non-SLE patients. This is largely derived from case reports and retrospective clinical analyses of SLE patients found to have the lupus anticoagulant.

Hart,<sup>24</sup> in a retrospective analysis of 145 young adults with cerebral infarction, identified the lupus anticoagulant in six (4%). Four of these patients met the American Rheumatism Association (ARA) criteria for SLE.<sup>25</sup> In 61 of their patients with a lupus anticoagulant, Vermeylen<sup>2</sup> identified nine cases of cerebral infarction in relatively young patients (five men age  $59 \pm 4$ ; four women average age  $49 \pm 4$  years). Gastineau<sup>23</sup> surveyed 219 patients with the lupus anticoagulant and found seven patients with "carotid/cerebrovascular" infarction. Six of these patients had SLE. Fisher<sup>26</sup> reported six patients with cerebral infarction and one with a transient ischemic attack, all of whom had the lupus anticoagulant. Three of these patients had thrombocytopenia, and only one met the ARA criteria for SLE. Landi<sup>27</sup> described two young women with recurrent cerebral and ocular ischemia in association with the lupus anticoagulant. Yagnik<sup>11</sup> described a young postpartum patient who developed a cerebral infarction secondary to a right internal carotid artery occlusion in the presence of the lupus anticoagulant.

An association with verrucous endocarditis was noted by D'Alton<sup>28</sup> who reported a young adult with

SLE who had a left hemispheric infarction and recurrent transient ischemic attacks. Echocardiogram revealed findings compatible with aortic regurgitation and thickening of the endocardium in the sub-mitral valve area and of the anterior mitral valve leaflet. Jacobsen<sup>29</sup> noted a familial occurrence when he described two brothers, both with recurrent cerebral infarctions and the lupus anticoagulant.

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**Livedo reticularis is a blanching reddish purple rash on the extremities seen in association with connective tissue disorders, cholesterol emboli, Raynaud's phenomena, and, importantly, with the primary antiphospholipid syndrome.**

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Levine,<sup>30</sup> adding eight personally observed patients and summarizing previously reported cases, found that lupus anticoagulant-related strokes occurred at a relatively young age (39 years). There was a female preponderance, and 34% of the patients had SLE. Some of the remaining patients had "lupus-like" illnesses. There was frequently associated thrombocytopenia, livedo reticularis, a history of venous thrombosis, and spontaneous abortions. Many patients also had amaurosis fugax. Reviewing the reported angiograms of these patients, Levine noted that they were either normal or demonstrated large vessel or branch occlusions.

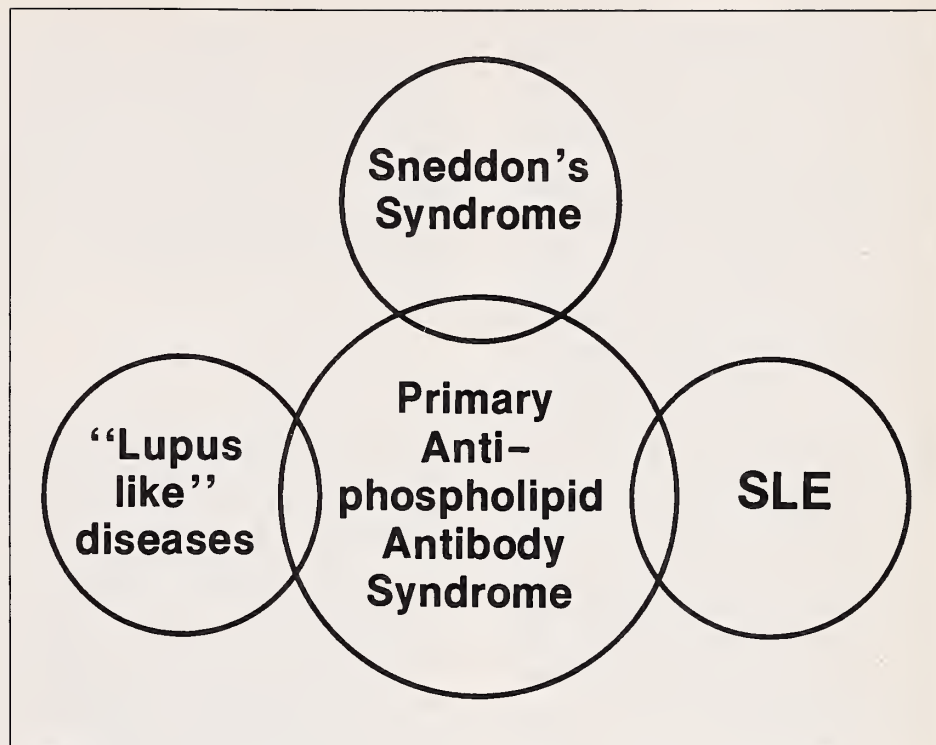
With the development of a radioimmunoassay to detect and measure anticardiolipin antibody in 1983, Harris<sup>31</sup> linked the presence



of the anticardiolipin antibody to thrombosis in SLE patients. Of his 15 patients with the highest anticardiolipin titer, there were five cerebral thromboses. Further refinement of techniques led to the availability of an ELISA test<sup>32</sup> to detect anticardiolipin antibodies. An international conference found it to be accurate, reproducible, and in accordance with the results of the radio immunoassay.<sup>33</sup> Since the introduction of these tests, there have been a series of reports of anticardiolipin antibodies in stroke patients.

Some of these reports highlight the discordancy between the anticardiolipin assay and the lupus anticoagulant test. Levine<sup>22</sup> reported three patients with cerebral infarction and anticardiolipin antibody who had undetectable lupus anticoagulant activity. The first case was in a 44-year-old woman who had four cerebral infarctions in the setting of a thymoma. The second patient was a 29-year-old woman with SLE who sustained multiple cerebral infarctions. The third patient was a 56-year-old man with a history of femoral artery thrombosis who experienced mesenteric artery thrombosis and a right frontoparietal cerebral infarction. Coull<sup>34</sup> reported four patients without SLE and without the lupus anticoagulant, all of whom had multiple cerebral infarctions and dementia in association with high anticardiolipin titers by ELISA test.

In a recently published collection of 35 case reports of cerebrovascular disease and antiphospholipid antibodies, 10 patients were found to have these antibodies in the absence of SLE.<sup>35</sup> These patients were young (mean age 38 years) and often had migraine, livedo reticularis, low titer ANA, and echocardiographic abnormalities. The concept of a primary antiphospholipid syndrome has emerged, distinct from SLE but with some overlapping features (Figure 1). These patients will typically present with strokes and transient ischemic attacks as their first manifestation. Many will have multiple strokes (Figure 2).



*The primary antiphospholipid antibody syndrome shares clinical and laboratory features with SLE, Sneddon's syndrome, and other collagen vascular diseases.*

**A** high prevalence of echocardiographic abnormalities has been noted in patients with antiphospholipid antibodies.<sup>35</sup> Typically there is thickening of the mi-

tral and aortic valves, and at times discrete vegetations are noted. In a pathologic study of cardiac valves in patients with antiphospholipid antibodies, there was evidence of



*Coronal MRI depicting both left and right hemisphere infarcts in a young patient with primary antiphospholipid syndrome.*



organizing thrombus.<sup>36</sup> Similar to Libman-Sacks endocarditis,<sup>37</sup> this is most marked on the ventricular surface of the mitral valve and the neighboring endocardium. Besides being a source of embolic material, this process can lead to valve malfunction and require valve replacement.<sup>38</sup> A form of nonbacterial thrombotic endocarditis and probably identical to Libman-Sacks endocarditis, these abnormalities are thought to reflect an underlying prothrombotic state.<sup>39</sup> At the Medical College of Georgia, we have seen four young patients with strokes and thickening of the mitral and aortic valve echocardiographically. These patients all fit into the category of primary antiphospholipid syndrome. Two had migraine, all four had thrombocytopenia, and one had livedo reticularis.

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### **Women with prior spontaneous abortions and antiphospholipid antibodies have had successful pregnancies after treatment with prednisone and aspirin.**

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Livedo reticularis is a blanching reddish purple rash usually found on the extremities. It is seen in association with connective tissue disorders, cholesterol emboli, Raynaud's phenomena, and, importantly, with the primary antiphospholipid syndrome. The association between livedo reticularis and stroke has been known as Sneddon's Syndrome.<sup>40</sup> These patients are often young women, and many have had multiple strokes. It now seems apparent that some of these cases are associated with antiphospholipid antibodies.<sup>35, 41</sup>

Amaurosis fugax and ocular ischemia have also been found in association with antiphospholipid antibodies.<sup>42</sup> These patients are typically young, have had multiple at-

tacks and generally have no evident carotid artery disease. Many have had "splinter" hemorrhages at their nail beds. In addition, that subset of SLE patients with retinal ischemia and infarction has been shown to have a high prevalence of antiphospholipid antibodies.<sup>43</sup>

### **Mechanism of Stroke**

The mechanism of stroke in patients with antiphospholipid antibodies is not always clear. Angiography has in general documented either large artery occlusion (i.e., internal carotid artery), branch occlusions, or has been normal.<sup>30</sup> "Beading" of the arteries to suggest arteritis has only been reported once.<sup>30</sup> As these patients often have cardiac valvular abnormalities, it is quite probable that the branch occlusions seen on angiogram represent emboli from a cardiac source.

There is little information concerning the pathologic examination of the involved vessels. In one report of an examined occluded common iliac artery in a patient with symptomatic cerebrovascular disease, new and organized thrombus formation was seen pathologically.<sup>44</sup> There was no evidence of vasculitis. In another patient with an aortic occlusion and antiphospholipid antibodies (positive anticardiolipin and positive lupus anticoagulant tests), noninflammatory intimal thickening and thrombus were found in the aorta.<sup>45</sup> In the only published pathologic case of a cerebral vessel, a thrombosed cerebral arteriole without inflammation was seen.<sup>46</sup> The limited pathologic material from anticardiolipin antibody-related thrombosis therefore indicates a noninflammatory vasculopathy.

The mechanism by which antiphospholipid antibodies produce thrombosis is unknown. Carreras<sup>47</sup> has suggested that antiphospholipid antibodies interfere with prostacyclin production and cites experimental evidence in which a patient's IgG fraction inhibited release of prostacyclin in rat aortic

tissue in vitro. This has been confirmed by others.<sup>12, 48</sup> An alternative hypothesis has been forwarded by Comp et al.,<sup>49</sup> in which antiphospholipid antibodies produce inhibition of thrombomodulin, an endothelial cofactor in the activation of protein C by thrombin. They reported inhibition of human thrombomodulin by an IgG fraction of two patients with lupus anticoagulant. This would serve to diminish the inhibition of the coagulation system by protein C and lead to a "functional" protein C deficiency. Protein C deficiency has been clearly linked to a prothrombotic state. Still others have suggested that antiphospholipid antibodies, by binding to platelets, increase their adhesiveness and thereby promote platelet aggregation.<sup>50</sup>

### **Prevalence of Antiphospholipid Antibodies**

A number of prevalence studies of anticardiolipin antibodies in SLE patients have been done. Sturfelt,<sup>51</sup> using the ELISA test, found anticardiolipin antibody in 54% of unselected SLE patients. Although a statistically significant correlation with thrombosis was not found here, the observation was made that all the strokes occurred in patients with very high anticardiolipin titers. Cronin<sup>52</sup> studied a group of 64 SLE patients selected for clinical findings associated with anticardiolipin antibody (i.e., spontaneous abortion, thromboses, thrombocytopenia). The most striking finding in this study was the strong correlation between cerebrovascular disease and high titers of IgG anticardiolipin antibody.

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### **Echocardiography should be performed on all stroke patients with antiphospholipid antibodies, with special attention to the aortic and mitral valves.**

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While prevalence studies of anticardiolipin antibody have been done in SLE patients, there have been no large scale published studies of the prevalence of anticardiolipin antibody and lupus anticoagulants in an unselected stroke population. In a group of 706 normal blood donors, 5% were found to have a positive anticardiolipin assay by ELISA.<sup>53</sup> In a study of 800 patients with thrombosis of all types, the prevalence of the lupus anticoagulant was less than 2%.<sup>20</sup> Harris<sup>54</sup> found a positive anticardiolipin antibody in two of 25 elderly patients he studied with stroke but in none of 30 controls. Brey<sup>55</sup> studied 16 young patients with cerebral ischemia and found that 4 of 16 had a positive anticardiolipin antibody. Eight of the 16 had an abnormal kaolin clotting time, an indicator of the lupus anticoagulant. Kushner<sup>56</sup> has found that in 48 patients with cerebral ischemia, 47% had either an abnormal tissue thromboplastin inhibition test, indicating a lupus anticoagulant or a positive anticardiolipin assay. At the Medical College of Georgia, we are presently engaged in a study to determine the prevalence of antiphospholipid antibodies in a stroke population.

**Antiphospholipid antibodies should be searched for in any young stroke patients and in all stroke patients with thrombocytopenia, a past history of venous thrombosis or spontaneous abortion, livedo reticularis, connective tissue disease symptoms, and migraine.**

## Treatment

There is no controlled study evaluating the treatment in patients with antiphospholipid antibodies and stroke. An association has been found between antiphospholipid antibodies and spontaneous abortions.<sup>57</sup> The basis for this is thought to be placental ischemia from thrombosis.<sup>58</sup> Women with prior

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**Although there are no firm data to support any specific therapy, we recommend the institution of warfarin therapy, as there is a high risk of stroke recurrence.**

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spontaneous abortions and antiphospholipid antibodies have had successful pregnancies after treatment with prednisone and aspirin.<sup>59</sup> This treatment concept has been extended to those patients with antiphospholipid antibodies and stroke, but there are no firm data to support this.

There appears to be a high stroke recurrence rate in this population, and recurrent strokes have been seen in association with warfarin withdrawal.<sup>60, 61</sup> As the mechanism of stroke almost certainly involves hypercoagulability, most clinicians are now using warfarin therapy, keeping the PT 1.3 to 1.5 control. Patients treated in this manner anecdotally have not had recurrence.

## Conclusions

While the prevalence of antiphospholipid antibodies in a stroke population is not known, the available data indicate that these antibodies make a significant contribution to stroke, particularly in the young. At the present time, the recommendations can be made that

these antibodies should be searched for in any young stroke patient and in all stroke patients with thrombocytopenia, a history of venous thrombosis or spontaneous abortion, livedo reticularis, connective tissue disease symptoms, and migraine. Although many patients will have a prolonged PTT, this is not a sensitive enough test and an anticardiolipin assay should be performed.

Echocardiography should be performed on all stroke patients with antiphospholipid antibodies, with special attention to the aortic and mitral valves. Although there are no firm data to support any specific therapy, we recommend the institution of warfarin therapy, as there is a high risk of stroke recurrence. Antiplatelet therapy with aspirin is a reasonable alternative, particularly in cases where compliance may be a problem.

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# Parental Satisfaction with Neonatal Intensive Care Services

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**Probing parents' satisfaction as consumers of medical services can provide a constructive outlet for their concerns and may foster feelings of parental competence and attachment in what can seem to be a forbidding and alien setting.**

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**P**ATIENT SATISFACTION with services is an important measure of the quality of care provided in inpatient hospital settings. When services are delivered to infants or very young children, it is appropriate to assess parents' satisfaction with the care their children receive. In 1987, as part of a larger study of the effectiveness of an innovative effort to provide social support to parents of infants in intensive care, parental satisfaction with neonatal intensive care services at the Medical Center of Central Georgia was measured.

Collecting information about parental satisfaction with experiences in a neonatal intensive care unit (NICU) is potentially valuable in several ways. First, this information provides valuable feedback for health professionals who administer such care.<sup>1</sup> In addition, utilization of consumer satisfaction data increases an agency's real and perceived effectiveness.<sup>2</sup> Furthermore, responding to parental concerns may help to buffer the stress of this family crisis. Parents of critically ill newborn infants typically report in-

tense emotional reactions, including sadness, preoccupation with thoughts of the baby, irritability, anxiety, guilt, and anger.<sup>3</sup> These feelings may play a role in the abnormally high incidence of subsequent problems in families of infants who were premature or otherwise abnormal at birth. The babies are at high risk for later child

abuse,<sup>4</sup> failure to thrive,<sup>5</sup> and overprotection.<sup>6</sup> In addition, we have observed that health professionals can be targets of the negative emotions experienced by NICU parents. Probing parents' satisfaction as consumers of medical services can provide a constructive outlet for their concerns and may foster feelings of parental competence and attachment in what can seem to be a forbidding and alien setting.

## Methods

Parents who provided consumer satisfaction ratings were volunteer participants in a study of the relative effectiveness of different mechanisms for provision of social support to families of infants in medical crisis. Approximately half the parents were black, and half were white. The majority were in their twenties, and all income and occupational levels were represented. There were 79 mothers and 20 fathers in the study.

The parents received either: (a) contacts by "veteran" parents (other volunteers whose babies had once been in the NICU) who offered to

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TABLE 1 — Parental Satisfaction with NICU Services at PRE Test, Medical Center of Central Georgia, 1987

<i>Items</i>	<i>Average Rating</i>	<i>Range</i>	<i>% Very Satisfied</i>	<i>Combined % Satisfied and Very Satisfied</i>
Travel	* (M) 4.46	3-5	54	99.1
	† (F) 4.35	3-5	45	90.0
Nurses' Treatment	(M) 4.70	3-5	77	92.6
	(F) 4.85	4-5	85	100
Staff Responsiveness	(M) 4.68	3-5	70.9	96.2
	(F) 4.60	4-5	60	100
Improvement	(M) 4.63	4-5	62.8	100
	(F) 4.80	4-5	80	100
Doctor's Helpfulness	(M) 4.71	2-5	76.9	96.2
	(F) 4.45	2-5	55	95
Doctor's Sensitivity	(M) 4.52	2-5	55.1	97.4
	(F) 4.55	4-5	55	100
Recommend Service to Others	(M) 4.91	3-5	92.3	98.7
	(F) 4.95	4-5	95	100
Feel You Can Use If Needed	(M) 4.81	3-5	82.3	98.7
	(F) 4.80	4-5	90	100
Overall Satisfaction	(M) 4.60	2-5	73.1	97.4
	(F) 4.80	4-5	80	100

*Note.* Range of scores is 1 to 5 with 1 very dissatisfied and 5 very satisfied.

\* Mothers, n = 79

† Fathers, n = 20

provide information and emotional support, (b) a staff-administered educational session comprised of videotaped and printed training materials describing the NICU experience and discussing coping strategies, or (c) standard hospital procedure in which a social worker was available to discuss concerns. The social worker was made available to members of the first two groups as well.

Near the outset of an hour-long interview (administered in either written or oral form at the preference of the parent), nine multiple choice questions about satisfaction with various aspects of service delivery were answered. Parents were given a 5-point scale of response alternatives, where 5 was equal to "very satisfied," 1 to "very dissatisfied," and 3 to "no particular feelings one way or the other." Space for comments was provided, and when services were rated as unsatisfactory, explanatory comments were solicited. Rated service components ranged from travel arrangements for hospital visitation to the sensitivity and helpfulness of physicians on the unit. The ratings and comments were obtained from each family shortly after the infant's admission to the NICU (PRE test), and

after the infants were well enough to be fed entirely by mouth (POST test). Some families were also interviewed briefly by phone at one or more midpoints between the PRE and POST treatment interview sessions.

### Consumer Satisfaction Results

Parents of infants in the NICU have more contact with nurses than with any other staff, so nurse ratings are presented in greatest detail here. Throughout the study, ratings and comments about nursing services at the Medical Center were overwhelmingly positive. At PRE test, 81% of the parents who rated nursing services indicated that nurses were doing absolutely everything they could to be helpful. Their helpfulness was further emphasized in comments. At POST test, 83.7% of the parents still participating in our study were maximally satisfied with the performance of the nursing staff, and added remarks about their high levels of concern, support, availability, and knowledge.

Comments providing constructive suggestions generally dealt with the parents' perceived need for more or earlier information and, in all but one case, were accompanied by

positive statements about the nursing staff. In that case, at PRE test a mother reported feeling rushed when she asked the nurses questions and thought the rules were changed too frequently. At a midpoint contact, the mother admitted having a problem with only one of the nurses, and by POST test she said she had talked to the staff member and had resolved the problem.

Ratings of services delivered by physicians were lower than those of services provided by nurses at PRE test, but slightly higher than nurses by POST test. Of combined responses by mothers and fathers at PRE test, 66% were very satisfied with the help offered by physicians, but 89.3% gave physicians this maximum rating by POST test. Again, many positive comments were made relating to the physicians' support and concern. Six parents had criticisms of physicians at PRE test focusing on a need for better explanations of hospital procedures, more encouragement or earlier information. In two of these cases, the comments referred to the delivery or admitting process prior to actual NICU contact.

In addition to many comments to the effect that physicians were con-



TABLE 2 — Parental Satisfaction with NICU Services at POST Test, Medical Center of Central Georgia, 1987

<i>Items</i>	<i>Average Rating</i>	<i>Range</i>	<i>% Very Satisfied</i>	<i>Combined % Satisfied and Very Satisfied</i>
Travel	* (M) 4.52	2-5	58.6	94.8
	† (F) 4.54	4-5	53.8	100
Nurses' Treatment	(M) 4.83	4-5	82.8	100
	(F) 4.85	4-5	84.6	100
Staff Responsiveness	(M) 4.72	3-5	75.9	96.6
	(F) 4.85	4-5	84.6	100
Improvement	(M) 4.80	4-5	79.3	100
	(F) 4.85	4-5	84.6	100
Doctor's Helpfulness	(M) 4.87	4-5	86.2	100
	(F) 4.93	4-5	92.3	100
Doctor's Sensitivity	(M) 4.52	2-5	55.2	98.3
	(F) 4.24	2-5	38.5	92.3
Recommend Service to Others	(M) 4.97	4-5	96.6	100
	(F) 4.93	4-5	92.3	100
Feel You Can Use If Needed	(M) 4.95	4-5	94.8	100
	(F) 4.93	4-5	92.3	100
Overall Satisfaction	(M) 4.90	4-5	89.7	100
	(F) 4.93	4-5	92.3	100

*Note.* Range of scores is 1 to 5 with 1 very dissatisfied and 5 very satisfied.

\* Mothers, n = 58

† Fathers, n = 13

cerned and informative, there were six suggestions at POST testing that physicians have more personal contact with parents, provide more explanation of daily problems, and be more aware of a parent's readiness to receive certain information about the infant. It should be noted that within an individual parent's comments over time there was a consistent progression from less satisfied to more satisfied. One father, for example, initially considered the doctors pessimistic, but by POST test described them as pessimistic but realistic, and considered the physicians' attitudes well balanced by the nurses' optimism and caring. He added that the NICU staff worked well as a team.

Data from all questionnaire items on PRE and POST tests are summarized in Tables 1 and 2 respectively, and indicate a very high overall level of parental satisfaction with various aspects of NICU service at the Medical Center. There were no significant differences between mean satisfaction ratings of parents assigned to different social support conditions. In other words, standard procedure was sufficient to elicit an average satisfaction rating across all items of 4.7 on the 5-point scale. Differences between the groups

were noted on other measures, however, and will be described in subsequent reports.

### Discussion

Whenever they are used in the human services, consumer satisfaction queries generate fairly positive reactions. Roughly 80% of any group of service recipients will indicate that they were satisfied with the services received. Psychologists have hypothesized that the positive skew in consumer satisfaction ratings may be the result of cognitive dissonance reduction, a kind of unconscious reasoning that occurs when raters (considering themselves discerning consumers) choose to participate throughout an entire program. The clients respond as if the program must have been worthwhile because they did not terminate involvement. An alternative explanation for the fact that most program recipients usually indicate that they are satisfied with services received is social desirability — satisfaction is obviously the answer the interviewer is looking for.<sup>7</sup>

The very high ratings of services in the NICU at the Medical Center of Central Georgia were probably

not the result of cognitive dissonance reduction, because parents have no nearby option for tertiary care for infants and would not feel collateral responsibility for low-quality care. Social desirability does not begin to account for the level of NICU satisfaction ratings which were almost 20 percentage points higher than what is generally observed.

### Comments providing constructive suggestions generally dealt with the parents' perceived need for more or earlier information.

The overall satisfaction of parents in this sample is even more striking because NICU services are delivered under extremely stressful circumstances to families in highly emotionally charged states. We

suspect that the very act of collecting consumer satisfaction data was perceived as a statement about our hospital's commitment to keeping lines of communication open and may actually have created some of the satisfaction. Evidence for such an interpretation is provided by the lack of significant differences between support conditions — even the control group in our social support study felt a substantial level of support!

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**There were suggestions that physicians have more personal contact with parents, provide more explanation of daily problems, and be more aware of a parent's readiness to receive certain information about the infant.**

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Collecting parental consumer satisfaction information promises to provide valuable information about the effectiveness of current procedures. Patterns of ratings suggest avenues of further, more rigorous research which, in turn, may have treatment implications. For example, there appears to be a difference in the range of satisfaction levels of mothers and fathers. It may also be the case that parents need the kind of care that nurses provide best during some parts of the NICU experience, while they need the kind of interaction doctors provide at other points.

The consumer satisfaction information may also help to prevent problems associated with parents

perceiving a lack of concern for their perceptions, feelings, and needs by personnel. In the demanding NICU environment where constant medical crises are the most compelling focus of staff attention, there is always danger that parents will feel pushed into the background. Constant direct care responsibilities of medical staff may diminish tolerance for additional paperwork, but we feel that obtaining input about parents' satisfaction with services may actually prevent time consuming staff/parent conflicts.

To take full advantage of such potential benefits and to monitor our progress related to parents' suggestions about improvements in service, a new staff member will routinely solicit parental satisfaction with NICU services as he or she coordinates our pilot program of social support. Interested program directors from other NICU's can receive further details about these efforts by contacting the first author of this paper.

#### **Acknowledgments**

We gratefully acknowledge the contributions of Dr. Chen-Kung Ho whose questions led to the implementation of this study and to Sara Landry, Hilda Hilliard and the staff of MCCG's NICU whose efforts and cooperation contributed to its successful completion.

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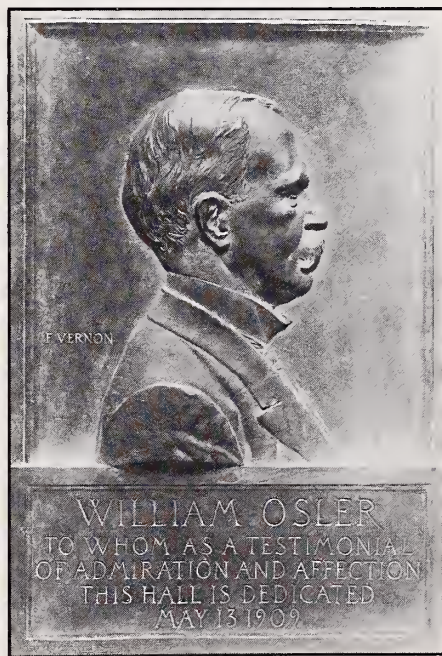
# In Search of Osler

Nicholas E. Davies, M.D., F.A.C.P.

**A**S WE DROVE into the narrow, wet High Street of Oxford, the sky was the color of well used bath water. My friend, Dee Canale, a neurosurgeon from Memphis, and I were in this ancient university town to attend a program entitled "Osler Revisited," arranged by Nicholas Dewey, Ph.D. a medical antiquarian book dealer cum medical history tour organizer.

## Getting Housed at Merton College

Headquarters for the group, some 40 of us, was Merton College. School was not in session, so we used the students' rooms. The youngest and most fit among us were given third floor rooms; I had mixed emotions about being assigned one of these. Walking to my room, I saw in the distance a high stone wall surrounding the college. The fields beyond the wall bordered the Thames (known in Oxford as the Isis) and there in the nearest field (which I have since learned was Christ Church Meadow) were perhaps 60 boys, aged 8 to 15, in rugby uniforms, scrumming away or doing whatever one does at rugby. I thought to myself, how typical this is of (my concept of) England.



*The famous Vernon plaque of Sir William Osler that is now in the Osler Library, McGill University, Montreal. A copy of this plaque was given to the John Radcliffe Hospital, Oxford, by the Osler Revisited group. Photograph courtesy of the National Library of Medicine.*

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Then up the three flights and into my room. It was cold, and the casement windows were opened wide with drab plaid polyester curtains flapping desultorily in the misty breeze. There was a bare oak desk, two plain semi-modern wooden chairs, a nondescript maroon carpet, and two space heaters, one with no plug and a frayed cord. On a corner chest that badly needed refinishing sat a lonely piece of ivy, struggling but clearly moribund. It had not been watered for days, perhaps weeks.

I closed the windows, pulled the curtains, turned on the bare overhead bulb and the one floor lamp, and lit the space heater. That did not do it. I unpacked my bags, put some books on the desk, hung a picture that I had been given earlier in my trip, and draped my jacket on the back of a chair. That still did not do it. I opened a bottle of Bell's Scotch Whiskey, poured a quantity into my only glass, added a bit of tepid tap water, sat in the chair near the desk in front of the heater which was turned on high and imagined that I was a Rhodes scholar spending his first day at Oxford. That did it. From that moment on my room with its tiny bedroom attached be-



came about as cozy as any bare room I have ever lived in.

The next hurdle was the shower, located on the second floor adjacent to the bathtub and toilet. Wearing my raincoat/bathrobe and carrying soap, towel, and clean underwear, I made my way to the shower, locked the door, and investigated. First of all, I found that the shower was in fact an overhead hose — the water came out slowly, cylindrically, straight down. Secondly, it came out cold, and I suspected that, unlike my room, no amount of Bell's Scotch Whiskey would make it seem warmer. I tried the tub next door and to my surprise there was both hot and cold water. For the first time in years I had an old fashioned steamy bath and for the first time all afternoon I felt pleasantly warm, inside and out.

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**Headquarters for the group, some 40 of us, was Merton College. The youngest and most fit among us were given third floor rooms; I had mixed emotions about being assigned one of these.**

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The bathing story would not be complete without saying that on the following day all of the boilers went down and there was no hot water for 4 days. Indeed, one couple moved to a local hotel and others moved to newer rooms in Merton College. But for those of us who stuck it out, living "on the economy" as it were, there developed an esprit de corps that will not be forgotten — or repeated.

That evening, a Tuesday, we had dinner in the College Hall, a large, high ceilinged, dark dining room with refectory tables and benches

bolted to the floor. Getting into and out of these seats was difficult for some of our older members and was especially awkward for the ladies whose skirts were long or tight. Yet we managed in good spirits and our dinners, served by young girls and old men, were always hearty, with plenty of peas, potatoes, carrots, and Brussels sprouts. Above us on the walls were portraits of famous graduates. The next morning I found that one of these was of Duns Scotus, the 13th century schoolman who both attended and taught at Merton. It was from his name that "dunce" was derived, first meaning pedant and later, fool. Thus it was from him that the dunce cap was ultimately derived. When I looked up from my breakfast oatmeal (porridge) at his stern countenance each morning, I had the vaguely uncomfortable feeling that had I been his pupil, I might have been one of the wearers of this object of derision.

#### **Doyens and Docents**

The week was spent immersed in Osleriana. We were welcomed to Merton College by the Domestic Bursar (I was afraid to ask if there was a Foreign Bursar) and learned that Merton's official colors are rouge (red), azure (blue), and gold.

Dr. Dewey set the scene with a delightful talk entitled, appropriately, "Setting the Scene, Osler's Golden Decade: 1907-1917." He was followed by Dr. George Harrell, a long-standing Oslerian who is an expert on Osler's family. It was an emotion-filled address made more poignant for the group by the presence of Dr. Marion Kelen, Osler's first cousin once removed. As Dr. Harrell spoke, the sun streamed through the windows, and a large butterfly found its way into the room. It sailed about majestically for a few moments before alighting on a curtain nearest the sunlight, and I wondered if perhaps this were really Sir William reincarnated. I concluded that it probably was not, unless Osler were in an E. Y. Davis (his alter ego) mood. Somehow butterflies do not seem to me to be his style.

Dr. Harrell was followed by Dr.

Robb-Smith, described by Dr. Dewey as "the doyen of Oslerians in Oxford." Dr. Robb-Smith spoke of Osler as though they had been friends, and he noted that as Regius Professor of Medicine, Osler was appointed by the Crown, not by the University. One of several additional jobs that came with the Regius Professorship was that of curator of "The Bodley" (Bodleian Library), a job that Osler, an avid bibliophile, found interesting and took very seriously. Dr. Robb-Smith pointed out that Osler started the *Bodleian Quarterly*. He also oversaw the purchase for £3000 of a Shakespearian folio in an Oxford binding that Oxford had sold centuries earlier as a surplus book!

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**We were welcomed to Merton College by the Domestic Bursar (I was afraid to ask if there was a Foreign Bursar) and learned that Merton's official colors were rouge, azure, and gold.**

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Dr. Robb-Smith spoke briefly of Osler's relationship to Dr. Geoffrey Keynes, who, like Osler, is one of my heroes. Keynes began compiling his bibliography of Sir Thomas Browne in 1908 while a student at Cambridge. Knowing of Osler's interest in Browne, Keynes visited him on many occasions and at each visit Osler exhorted him to get on with the job. Despite Osler's prodding, the bibliography was not complete until 1924, some 5 years after Osler's death. Dr. Robb-Smith editorialized that it takes *anyone* 20 years to compile a good bibliography; Keynes was no exception.

This was a full dose of Osler for our first morning and Dr. Dewey, ever punctual, rushed us off to



Green College to meet Sir John Walton, Warden (equivalent to president) of Green College, and his gracious wife. After a sherry reception we had a delightful lunch in the Observatory, followed by a tour of the College. I have since learned that Sir John is an outstanding neurologist, an Osler scholar, a past president of the British Medical Association, a past president of the Royal Society of Medicine, and Chairman of the General Medical Council of Great Britain.

Sir John took the group to 13 Norham Gardens, the Osler's comfortable home known as "The Open Arms" that is now managed by Green College. Here Sir William and Lady Osler lived most of their days in England, entertaining students, faculty and visitors to Oxford, and during World War I, many hundreds of Canadian and American soldiers. Upon her death, Lady Osler bequeathed the house to Oxford to be used by Regius Professors. Some have used it, some have not. Presently the house serves as a working museum, housing a visiting scholar while keeping in place some of the memorabilia accumulated by the Oslers. Sir John has begun an ambitious refurbishing project that will restore the house to its original condition.

#### **Bean Speaks, A Plaque Is Presented**

Like children in an amusement park, our group of hard-core Oslerians found each new event more interesting than the last. That evening found us at a banquet in the Hall. It can be described as British elegant — intended to be neither oxymoronic nor pejorative — with good food, good wine, good service, and wonderful conversation, all set in the majestically panelled, spacious, baronial room. William B. Bean, Sir William Osler Professor of Medicine Emeritus at the University of Iowa and an old friend from the University of Virginia, spoke on Osler's last 3 months at Johns Hopkins, 3 months filled with consultations, good-bye banquets,



*Sir William and Lady Osler with their son, Revere, in the garden of "Open Arms," their home at 13 Norham Gardens, Oxford, in June 1905. Photography courtesy of the Osler Library, McGill University, Montreal.*

and the famous "Fixed Period" address in which Osler was accused of propounding euthanasia. According to Dr. Bean, it was from this incident that the verb "Oslerize" was coined, meaning "put to death at age 60." Dr. Bean spoke without notes, at the end of a very full day, following a heavy meal with much wine. He spoke eloquently and with great humor. He is a remarkable man.

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**Dr. Robb-Smith spoke of Osler as though they had been friends, and he noted that as Regius Professor of Medicine, Osler was appointed by the Crown, not by the University.**

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So what does an Osler Revisited group do after a full day followed by a long evening? It gets up early, eats quickly, and heads for more

Osleriana. (My wife, who declined to accompany me on this trip, insists that I am a member of a cult. Depending upon how one defines cult, she may be correct.) We traveled by bus to the John Radcliffe Hospital (not to be confused with the Radcliffe Infirmary) on the outskirts of town, a large modern hospital that is the teaching hospital for the Oxford Medical School. After elegant welcoming speeches from several of the hospital's leaders, our members presented papers on Osler's relationship to pediatrics, surgery, neurology, and pathology. All were excellent.

Following lunch our group presented a replica of the Vernon plaque to the Radcliffe Hospital. It was unveiled by Dr. Alex Cooke, Osler's last surviving pupil, an elderly but very spry gentleman in his late 80s. Then back to Merton for a "rest period" during which time I learned to operate an English coin laundry and visited the bookstores on the High Street. That evening most of us went to a play called "Top People." As Dr. Bean wrote later, "We saw certainly the worse play I have ever seen or thought about. There was a melancholy announcement to the effect that it was to appear in London the next week." I left at the end of the first act.





*Sir William Osler standing in front of the fireplace in his home at 13 Norham Gardens shortly before his death in 1919. Photograph courtesy of the National Library of Medicine.*

### Oxford Walk-about

Thursday's search for Osler began with a grand walk-about of Oxford, starting on the High Street. We first visited the Examination Schools, which during World War I were converted into hospitals where Osler worked. (While there are some 40 colleges in Oxford University such as Merton, Green, Balliol, etc., all students must take their examinations in these halls.) We stopped at the Radcliffe Camera, perhaps the most famous building in Oxford, now used as a reading room. Next came the wonderful Bodleian Library itself, where we had a typically erudite, witty, understated British lecture by an assistant librarian while we were seated in a darkly paneled, understatedly elegant room. For a library buff, this was the highlight of the trip.

Then on to Christopher Wren's Sheldonian Theatre, where most of the ceremonial functions of the University are held. We climbed to the top for a marvelous view of the city. After visiting the old Ashmolean Museum (my thoughts turned to Johnny Mercer and the New Ashmolean Marching Society and Students Conservatory Band), we walked to Rhodes House, the headquarters for the Rhodes Scholarship. On the walls of its marmoreal halls hung portraits of former scholars. The only portrait of a physician that I found was that of Wilder Penfield.

Following lunch we divided into three groups, one to tour Oxford's gardens, one to the Science Museum, and one to the Christ Church library. I chose the latter. Containing priceless items, it is rarely open to the public. The reading stools we sat on as the library was described

to us were 18th century Chippendale originals. There were 32 of them. I counted. Christ Church had many famous pupils and dons, among them John Ruskin, W. H. Auden, and the one known best to me, the Rev. Charles Dodgson, a.k.a. Lewis Carroll. It was here that Carroll wrote *Alice in Wonderland* for Alice Liddell, the daughter of the Dean of Christ Church.

That evening we heard two erudite lectures on Osler, the first by Mary Kingsbury, Ph.D., a member of our group from the University of North Carolina, whose title was "Congenial Associates." Dr. Kingsbury analyzed Osler's biographic writings and compared them with biographies of the past. She concluded that Osler wrote great introductions, was not compulsive about identifying his sources, often finished his pieces with quotations, and usually wrote in the 19th century panegyric style, omitting all of the bad things that his subjects might have done during their lifetime. The second speaker, Dr. Anthony Batty-Shaw, spoke of Osler's relationship to Norfolk, England, the home of Sir Thomas Browne, and, incidentally the home of Dr. Batty-Shaw.

### Into the Countryside

Friday was spent visiting Osler-related places within a few miles of Oxford. We began at Ewelme (pronounced Ewe-elm), a combination

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**While at John Hopkins, Osler delivered the famous "Fixed Period" address, after which he was accused of propounding euthanasia. It was from this incident that the verb "Oslerize" was coined, meaning "put to death at age 60."**

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of almshouse, school, church, and graveyard over which, as Regius Professor of Medicine, Osler was Warden. This, like being curator of "The Bodley," was an add-on, but one that Osler enjoyed and took quite seriously. Ewelme was built, we were told, to be used only by relatives of Chaucer. Indeed, there was a family tree of the Chaucers on one of the walls. School was in session as we visited, and there were perhaps 40 children between 6 and 14 in a two-room schoolhouse. From talking with the teachers we suspected that these children received an excellent start in life.

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**He wrote great introductions, was not compulsive about identifying his sources, often finished his pieces with quotations, and usually wrote in the 19th century panegyric style, omitting all of the bad things his subjects might have done during their lifetime.**

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The almshouse was certainly not out of Dickens. Each pensioner had a three or four room flat that was wonderfully light and airy. There were flowers everywhere, onions drying in the sun, and small gardens nearby. I thought how pleased my elderly patients would be to live in a place like this.

From Ewelme we visited Nuffield Place, home of the Viscount Nuffield, a great benefactor of Oxford Medicine, and then on to Cliveden, the magnificent estate of Nancy and Waldorf Astor which served as a hospital during World War I. Osler was a frequent visitor to Cliveden,

helping care for wounded American and Canadian soldiers who were sent there to recuperate. That evening we were free to go our separate ways. With five other Oslerians I went to a nice French restaurant and had an excellent dinner without a single pea, potato, carrot, or Brussels sprout.

Saturday morning was spent at Blenheim Palace and the afternoon at Blackwell's Book Store. I have yet to decide which is the more formidable. That evening we were guests at the Radcliffe Infirmary for cocktails and dinner, hearing a fascinating talk on medicine during the Boer War by Mr. Emmanuel Lee, a consultant surgeon.

### Sunday in Oxford

It was Harvest Sunday, and Dee Canale, Mary Kingsbury, and I found a parish church, St. Aldays, near Merton, that was filled with students and townspeople. The service involved the children of the congregation and was delightful. That afternoon we were guests at the Cloisters of Christ Church Cathedral, touring the cathedral with the verger, attending a reception, followed by Evensong at six, certainly the most beautiful experience of our trip. The priest was a friend of Dr. Dewey's, so we had a prayer said for us and for the memory of Sir William. One of our group, James Knight of New Orleans, an ordained minister, was asked to read the first lesson which he did very well. The boys choir was magnificent. We left the cathedral, ate quickly at Merton, boarded a bus for a short trip to London, and checked into the Clifton Ford Hotel, two centuries and four stars more advanced than our quarters at Merton College.

### Oslerians in London

So what does one do on a lovely Monday morning in London? Westminster Abbey? The British Museum? Harrods? No, I walked about the city looking for a Merton College necktie that I had forgotten to purchase in Oxford. I saw a lot of ties in a lot of stores but none officially belonged to Merton College.

The tie search was halted by an appointment to meet Stephen Lock, editor of the *British Medical Journal*. I was given a tour of the *BMJ* offices and met Ruth Holland, a writer whom I had admired from afar for her wonderful book reviews and occasional poems.

That afternoon we had an extensive tour of the Royal College of Physicians who had assembled all of their Osleriana for our group. That evening, our last in London, we assembled at Lettsom House, headquarters of the Medical Society of London, to meet with members of the Osler Club of London whose president was Dr. Alex Sakula. Dr. Sakula had visited Piedmont Hospital in Atlanta where he talked on Laennec, so it was nice seeing him again. After dinner we heard papers on Osler's birthplace at Bond Head, a discussion of his "Welsh Connection," a paper on "The Twilight Years of Lady Osler," and an address by Dr. Sakula entitled "WO and Rudyard Kipling." It was another long, full, interesting day of Osleriana.

### Denouement

Dee Canale and I returned to Atlanta the following morning. I wore my Osler Society tie which is navy blue and has inscribed on it in white, "Aequanimitas." It is the same tie that is worn on Fridays by alumni of the Osler Service of the Johns Hopkins Hospital. A flight attendant noticed the inscription and asked what it meant. I answered, "Keep cool." She said, "I've got to have that tie." She insisted, so I tied it on her and she wore it for most of the trip to Atlanta until her crew chief made her give it up, for which she paid me as rent one Budweiser.

Speaking of ties, in December I received a Merton College tie sent by Dr. Dewey's assistant, Julie. The heraldic figure on it is a small chevron of alternating rouge and ore stripes, placed on a background of rich, deep azure. It is my favorite.

### Acknowledgments

The author thanks Garland Davies, Mark Silverman, and Faith Wallis for help in preparing this manuscript. ■

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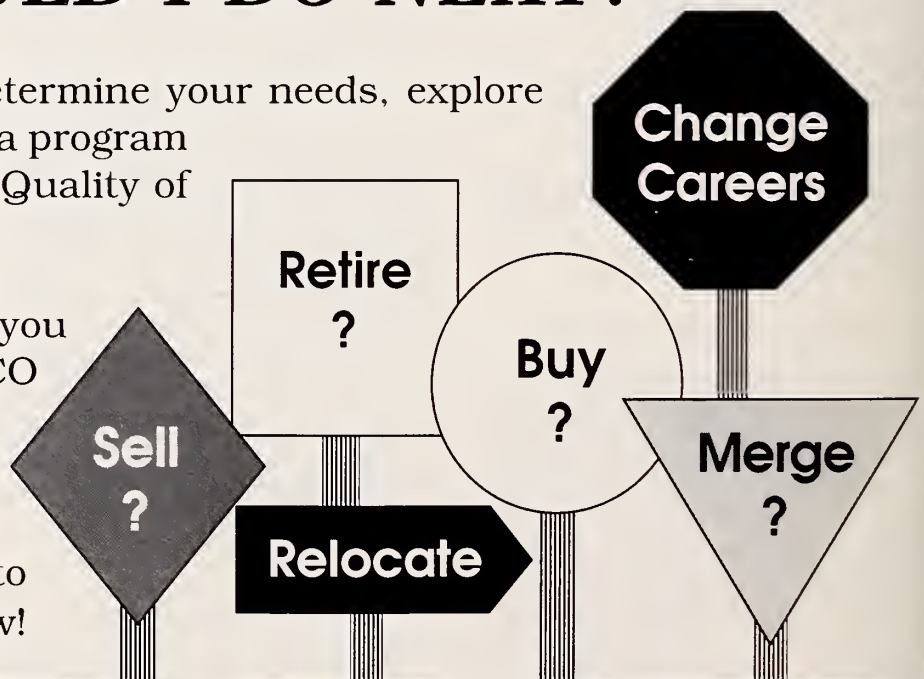
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# Continuing Medical Education Requirements for Hospital Medical Staffs

Robert C. Fore, Ed.D.

## Introduction

**M**ANDATORY continuing medical education (CME) has historically been met with resistance by the American Medical Association, the majority of its component state medical associations, and most national specialty societies. The issue dates back at least to 1947 when the then American Academy of General Practice established a CME requirement in its bylaws.<sup>1</sup> Although strong arguments have been presented for and against mandatory participation, CME has remained largely a voluntary activity.<sup>2-7</sup> Nevertheless, as of January, 1989, some form of mandatory CME was required by 11 state medical associations, 24 state medical licensing boards, and six national specialty societies.<sup>8</sup> Additionally, the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) *Accreditation Manual for Hospitals* includes a CME requirement in its Medical Staff Chapter (MS.7).<sup>9</sup> The Medical Association of Georgia does not require CME for membership, nor does the Composite Board of Medical Examiners for licensure.

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**Although mandatory CME for relicensure has been proposed in the Georgia General Assembly, no legislation to date has been passed. The issue is almost certain to reappear in future legislative sessions.**

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Accordingly, mandatory CME appears to be a function of the following: (1) membership in a state medical association with a CME requirement; (2) membership in a national specialty society with a CME requirement; (3) medical licensure by a state board of medical examiners with a CME requirement; and/or (4) membership on a hospital medical staff whose bylaws include

a CME requirement. It is possible, therefore, for some physicians to face up to four sets of mandatory CME requirements, albeit similar or identical, while other physicians face no CME requirements whatsoever.

Clearly, there is no national standard for CME participation. Where mandatory requirements are in effect, the American Medical Association Physician's Recognition Award is widely accepted.<sup>8</sup> The Physician's Recognition Award (PRA) was established in 1968 by the American Medical Association in an attempt to stimulate CME participation through a voluntary recognition program.

Since the majority of state medical associations, national specialty societies and state boards of medical examiners have no mandatory CME requirements, the most widespread requirement for CME participation is contained in the JCAHO Medical Staff Standard (MS.7).<sup>9</sup> This standard is as follows:

**MS.7** All individuals with delineated clinical privileges participate in continuing education.

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### *Required Characteristics*

MS.7.1 Each individual with delineated clinical privileges participates in continuing education activities that relate, in part, to the privileges granted.

MS.7.2 Hospital-sponsored educational activities are offered.

MS.7.2.1 These activities relate, at least in part, to

MS.7.2.1.1 the type and nature of care offered by the hospital;

MS.7.2.1.2 the findings of quality assurance activities; and

MS.7.2.1.3 the expressed educational needs of individuals with clinical privileges.

MS.7.3 Each individual's participation in continuing education is

MS.7.3.1 documented; and

MS.7.3.2 considered at the time of reappointment to the medical staff and/or renewal or revision of individual clinical privileges.

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**A survey questionnaire was mailed to CEOs of all institutional members of the Georgia Hospital Association and to selected non-members. Respondents were asked if their hospital provided CME for its medical staff.**

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The primary thrust of JCAHO Standard MS.7 is to encourage physicians to participate in CME.<sup>9</sup> There is no minimum number of credit hours nor specified mode of documentation. According to an April 12, 1989 letter from Peter Van Schoonhoven, MD, Associate Director, JCAHO Department of Standards, there is "...considerable flexibility" in JCAHO standards relating to CME.

### **Purpose**

The primary purpose of this study was to identify CME requirements for medical staffs in Georgia hospitals. The following research questions guided the study:

1) What is the extent of hospital-based CME in Georgia?

2) To what extent are CME requirements linked to clinical privileges?

3) When CME is required for clinical privileges, what are typical criteria for participation and documentation?

4) Does the provision of hospital-based CME result in mandatory requirements?

5) Does accreditation as a sponsor of CME result in mandatory requirements?

### **Methodology**

This was descriptive survey research. A survey questionnaire was mailed to chief executive officers of all institutional members of the Georgia Hospital Association and to selected non-members. The sample included for-profit, not-for-profit, general, chemical, and psychiatric hospitals. A cover letter summarized the JCAHO medical staff standard for CME and requested a response to a 10-item questionnaire. The questionnaire allowed for anonymity and assured that each institution in the sample would receive the results.

Descriptive statistics were used to summarize, organize, and interpret the data. Data were recorded and tabulated utilizing IBM PC compatible software entitled Survey Master produced by Masterware, Seattle, Washington.

### **Results**

The sample included 188 hospitals out of the 225 licensed hospitals in Georgia as reported by the Standards and Licensure Section of the Office of Regulatory Service. There were 90 completed surveys returned with a response rate of 48%. One survey was returned indicating the hospital had closed in

1988. The majority of respondents ( $n = 70$ , 78%) indicated their hospital was JCAHO accredited. Almost a third, ( $n = 28$ , 31%) reported accreditation by the Medical Association of Georgia as an intrastate CME sponsor. Of the hospitals which were not accredited CME sponsors, 7 (8%) reported that they plan to apply. Based on written comments and follow-up telephone calls, it was determined that surveys were completed by CEOs, medical staff chairs, CME Committee chairs, CME staff, and secretaries.

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**Although hospitals appear to be adhering to the intent of JCAHO standards relating to CME, a more consistent approach throughout the state could arguably diffuse legislative attempts toward mandatory CME for relicensure.**

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Respondents were asked if their hospital provided CME activities for its medical staff. Neither the size of the hospital nor the number or frequency of programs were considered. These activities could range from an on-going accredited program to presentations through Hospital Satellite Network or the Georgia Hospital Association TELNET to an occasional speaker sponsored by a pharmaceutical company. Most hospitals ( $n = 73$ , 81%) reported that they provide CME activities. Additionally, a majority ( $n = 50$ , 56%) link CME participation to clinical privileges, but few ( $n = 11$ , 12%) specify a minimum credit hour re-



quirement. Of the 11 respondents which specified a minimum credit hour requirement, results were as follows: 20 credit hours, 4 hospitals; 25 credit hours, 1 hospital; 40 credit hours, 1 hospital; 50 credit hours, 5 hospitals. The most frequently cited time periods for reporting CME credits were annually ( $n = 17, 19\%$ ) and bi-annually ( $n = 12, 13\%$ ). The majority ( $n = 61, 68\%$ ) did not indicate any specific time period for reporting.

Although some hospitals report no CME requirements, they still insist on documentation of participation ( $n = 21, 23\%$ ). Overall, a large majority require some form of documentation of CME participation ( $n = 68, 76\%$ ). The most frequently accepted forms of documentation are included in Table 1.

Of the 73 hospitals (81%) which provide CME activities, 41 (56%) include a CME requirement, while 32 (44%) do not. Of the total sample of 90 hospitals, 9 hospitals (10%) specify a CME requirement even though they do not provide CME opportunities.

## While CME requirements, if any, vary considerably, most hospitals raise the issue of CME participation by requesting some form of documentation for renewal of clinical privileges.

Finally, hospitals which have made a strong commitment to CME through accreditation as intrastate sponsors seem to be less likely to establish a CME requirement. Of the 28 accredited respondents, only 14 (50%) indicated they required CME for clinical privileges, while 35 (56%) of non-accredited hospitals had such a requirement.

TABLE 1 — Frequently Accepted Forms of CME Documentation

<i>Documentation</i>	<i>Number of Hospitals</i>	<i>Percentage</i>
CME Transcript Only	25	37
Attestation Only	19	28
Transcript or Attestation	8	12
Transcript, Attestation, or AMA Physician's Recognition Award	7	10
Transcript or AMA Physician's Recognition Award	4	6
Attestation or AMA Physician's Recognition Award	3	4
AMA Physician's Recognition Award Only	2	3
	<b>N = 68</b>	<b>100</b>

## Discussion

Even though this survey was mailed with no follow-up mailing or added incentives for responding, the response rate (48%) suggests that the issue of CME for hospital medical staffs in Georgia is viewed as important. Although mandatory CME for relicensure has been proposed in the Georgia General Assembly, no legislation to date has been passed. The issue is almost certain to reappear in future legislative sessions.

Data suggest that hospitals are attempting to provide local CME opportunities and are encouraging their medical staffs to participate. While CME requirements, if any, vary considerably, most hospitals raise the issue of CME participation by requesting some form of documentation for renewal of clinical privileges. Although hospitals appear to be adhering to the intent of JCAHO standards relating to CME, a more consistent approach throughout the state could arguably diffuse legislative attempts toward mandatory CME for relicensure.

The results of this study coupled with model CME standards developed by the Medical Association of Georgia CME Committee should be helpful to hospital CEO's, hospital

medical staffs, and hospital CME committees interested in establishing more consistent criteria for CME participation.

## Acknowledgments

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

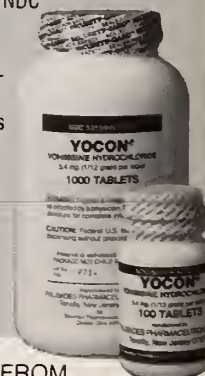
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# Retirement of a Surgeon

## Part I: Freedom and Happiness

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**Several years before retirement, my plan was to ease out of the practice, rather than the traditional target date and newspaper announcement.**

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**D**ESPITE MODERN day dogma, most doctors would agree that every person is different from all others. So it could be that very few of my colleagues will readily identify with my concept and enjoyment of retirement. When asked to define my state of mind, I could only think of one phrase: freedom and happiness. When asked to explain the journey necessary to arrive at this ethereal state (after ruling out Tabes and senility), I recalled several steps which seemed essential.

Every physician has worked very hard to have the privilege of saving the lives of others. Our unique profession leaves little time for self-evaluation, and even less time for self-protection. As I see it, there are three facets that we must acknowledge in order to prepare for our lifespans: economic, scientific, and humanitarian.

My economic rule was to evaluate my monetary status and my financial strategy at least every year. Term insurance in the early and middle of a career leaves more earnings for retirement vehicles such as IRAs and other retirement plans. Single Premium Variable Life Insurance (you invest the money)

and annuities are good for later years. Trusts are good for increasing your net worth. For example, you can establish an irrevocable trust (if you expect to retain your present wife and kids) and place your office and other assets in the trust. The rent that you pay to the trust plus interest can be used to educate your children and increase the family net worth.

A living revocable trust can be designed to coincide with your estate plan and your will. Be sure that your will provides for a bypass provision, so as to save your children from high estate taxes (which start at 37%).

**S**everal years before retirement, my plan was to ease out of the practice, rather than the traditional target date and newspaper an-

nouncement. My associates and I agreed to individualize our charges and sum up the aggregate at the end of each month. The percentage of work for each doctor established the percentage of his cost for the overhead. Thus, the less work that I produced, the less the cost to me. This system enabled me to start telling my patients that I would be phasing out, and it allowed my patients to gradually accept my associates. The patients were given free choice of physicians, so the transition was smooth.

The scientific side was relatively easy. For years, I had participated in the educational committee at our hospital. I still go to several conferences a week and have continued to attend national meetings and postgraduate courses. A friend recently said "You know that you are old when you know the answer, but no one asks the question!" Even if contrived, I still enjoy being asked to teach some of the classes or provide counsel.

Miraculously, the desire to remove organs and stamp out disease completely disappeared when I cleaned out my locker and left the operating room. The feverish drive

and ubiquitous fatigue gave way to tranquil satisfaction and peaceful exhilaration.

The humanitarian aspect of a physician is supreme. Who among us would have given the years of sacrifice without a burning desire to help our fellow man? Our very souls have been blessed by the privilege of bringing "healing to some, but comfort to all."

**A** very close friend once said, "Always leave a party when you are having fun!" My decision to retire was accompanied by the realization that as a busy surgeon I had fun, and as a responsible citizen, I could continue to enjoy helping others. Our participation in daily community life is but a continuation of the desire to serve our fellow man. From the golf course to the church and all in between, one can comfort and assure. The freedom to sleep all night, to do things on your own terms, to be with your family and friends, to augment the constructive elements of daily life — all of these things contribute to happiness.

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**When asked to explain the journey necessary to arrive at this ethereal state (after ruling out Tabes and senility), I recalled several steps which seemed essential.**

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My fervent prayer is that all physicians who finally retire will also find freedom and happiness. In the words of the Westminster Catechism: "Man's chief end is to glorify God, and enjoy Him forever."

*An Anonymous Surgeon*

# Myths or Facts?

- Even moderate social drinkers may risk liver damage.
- Women are more likely to suffer liver damage from alcohol than men.
- Most victims of liver disease are *not* alcoholics.

All three statements are *true*.

How many did you get right?

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# The History of Chinese Medicine

## Part One of a Series

Charles B. Gillespie, M.D.

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**The modern development of acupuncture occurred during the Song Dynasty when two lifesize bronze models were made to train acupuncture personnel. The models showed channels, organs, and points for insertion of needles for specific conditions.**

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this period of history. Academic thoughts were active, and medical practitioners summed up past and current medical experience. As a result, an important medical book, *Nei Jing*, came into being.

*Nei Jing*, also known as *Huang*

---

Dr. Gillespie is an orthopedic surgeon. He visited China last May during the recent demonstrations by the Chinese people. This series will reveal some of what he learned about the Chinese Traditional and Western styles of medical care. Send reprint requests to him at 810 14th St., Albany, GA 31708.

*Di Nei Jing*, consists of eighteen volumes and is the oldest medical book existing in China and perhaps even in the world. It was probably written collectively by many doctors and focuses on the fundamental theory of Chinese medicine. It also deals with anatomy, physiology, pathology, health care, diagnosis, acupuncture, and principles of treatment. These extensive volumes laid the foundation of all Chinese traditional medicine to be practiced in the future.

The *Treatise on Febrile and Other Diseases*, written by the distinguished Doctor Zhang Zhongjing (150 to 219 A.D.) at the end of the Han Dynasty, is the first important work on clinical treatment. In sixteen volumes, the book sums up medical experience in diagnosing and treating typhoid and other mainly internal diseases. The author created the theory of "judging the symptoms before making treatment." He referred to the practice of "decoction" (prepare by boiling to achieve extracts) to arrive at agents that could be used in treating sick people. Even in today's

**T**HE ORIGINS of Chinese medicine are lost in legend, but it is said that in ancient times a man named Shen Nong sampled hundreds of herbs in order to find cures for illnesses prevalent at the time.

Archaeological relics dating back to the Xia and Shang Dynasties (21st-16th centuries B.C. and 16th-11th centuries B.C., respectively) include cauldrons, jars, basins, and bowls. These vessels made possible the brewing of medicines in which the healing properties of herbs are extracted by boiling in water or other liquids. Inscriptions on bones and tortise shells dating back to the Shang Dynasty show that medicinal wine was in common use at that time.

Medical specialization developed early in China. As early as the Shang Dynasty, some Chinese doctors became nutritional specialists while others were physicians, surgeons, or veterinarians.

The theoretical system of Chinese medicine took shape from the Warring States Periods to the Three Kingdoms (475 B.C. to 265 A.D.). China changed dramatically during

China, this theory is still widely held, especially by the so-called "traditional" Chinese doctors.

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**In 581 A.D., the first medical college in the world (Agency of Royal Doctors) was established and became the most authoritative institution of medical education and hospital care in the entire world.**

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During the period of 265-1279 A.D., the taking of the pulse received great emphasis as a diagnostic step in Chinese medicine. In the ten volume *Classic on the Pulse*, Doctor Wang Shuhe assembled ancient theories on the doctrine of the significance of pulse evaluation. Apparently this contribution gained wide acceptance as the theory was included in other widely distributed books, such as the *Canon of Medicine* by Avicenna.

**B**efore the Han Dynasty, medical personnel were trained using father-to-son or master-to-apprentice techniques. In 581 A.D., the first medical college in the world (Agency of Royal Doctors) was established and became the most authoritative institution of medical education and hospital care in the entire world.

During the Tang Dynasty, the scale of the Agency of Royal Doctors was enlarged while at the same time, subjects were subdivided into smaller ones and the length of study was made more definite. In the newly established department of medicine, students of various ages prepared themselves over a period of 3 to 7 years, depending on their major subject. In the pharmacy de-

partment (materia medica), students of the ages 16 to 20 years studied the growth, collection, processing, storage, and compatibility of medical herbs.

Among the renowned doctors of the Tang Dynasty, Sun Simiao was probably the greatest. Enjoying a long life of 101 years (581-682), he wrote two important medical books: *The Thousand Gold Formulae* and *Supplement to the Thousand Gold Formulae*. In these books, he discusses the treatment of disease, especially those of women and children. He believed that gynecology and pediatrics were specialties to themselves and put them at the very beginning of his book. He confirmed the curative power of nutrition; he argued that any disease should first be treated with good food and a balanced diet.

In the Song Dynasty, because of the wide use of printing and encouragement of the royal family, important medical books were published and a bureau of medicine was established.

**A**cupuncture is distinctively Chinese, although it has long been introduced to other countries. Much of *Nei Jing* dealt with acupuncture, but its modern development occurred during the Song Dynasty when two life-size bronze models were made to train acupuncture personnel. The models showed channels, organs, and points for insertion of needles for specific conditions. Wang Weiyi also wrote a three volume text called

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**In the Song Dynasty, because of the wide use of printing and the encouragement of the royal family, important medical books were published and a bureau of medicine was established.**

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*Illustrated Manual on the Points for Acupuncture and Moxibustion on the Bronze Figure*. (More on Moxibustion in a later article.)

During the Ming Dynasty, the significant *Compendium of Materia Medica* was written by Li Shizhen during the period 1518 to 1593. This text describes the use of 1,892 medicines and 11,091 prescriptions. It also includes 1,110 illustrations related to vegetable, animal, and mineral remedies. He also lists the producing area, shape, nature, function, collection, and preparation process of each medicine. For 30 years, he climbed mountains to collect medicinal herbs which were described in his great work of 1,900,000 Chinese characters. Perhaps his greatest contribution was that of attempting to correct the medical practice errors of the past.

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**In the 16th century B.C., Li Shizhen spent much of his life climbing mountains to collect medicinal herbs which were described in his great work of 1,900,000 Chinese characters.**

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During the Ming and Qing Dynasties, many more medical books were published, thanks to the further development of the printing industry. According to what statistics that exist, more than 8,000 kinds of medical works, in more than 100,000 volumes, were produced during these times in history. Many of these volumes have been recovered and are preserved in medical museums throughout China.

In the January *Journal* the subject of discussion will be: "How does a traditional Chinese physician treat a patient?" ■



## *Taxpayer's Bill of Rights: Much Ado About Nothing*

Barbara B. Stalzer

***“This article reviews some of the major TAMRA provisions and changes in the Internal Revenue Code and suggests how they may be useful in a tax audit or collection situation.”***

**T**HE TECHNICAL and Miscellaneous Revenue act of 1988 (TAMRA) included a “Taxpayer’s Bill of Rights” which received much media attention and offered hope of substantive taxpayer benefits when it was first introduced. However, as finally enacted by Congress, the changes from earlier law brought about by TAMRA appear to be small, and their actual effect upon the examination of tax returns and the collection of taxes by the Internal Revenue Service (IRS) is probably minimal. This article will review some of the major TAMRA provisions and changes in the Internal Revenue Code and suggest how they may be useful in a tax audit or collection situation.<sup>1</sup>

### **Tape Recording Interviews**

Under TAMRA, a new section 7520 is added to the Code, detailing new procedures involving taxpayer interviews. This section allows both the taxpayer and the IRS to record certain types of interviews or meetings, upon advance notice. The new provision covers “in-person interviews,” including meetings between IRS officials and either the taxpayer or the taxpayer’s representative; it does not cover

telephone interviews. If the IRS records the interview and the taxpayer wishes to have a transcript or copy of the recording, the taxpayer must pay the applicable cost. This may be a useful tool to have if the taxpayer feels the IRS agent has an “attitude problem,” or where there are many complex issues in the audit. It could also be an evidentiary tool, where the taxpayer believes the position of the IRS is unreasonable and unjustifiable and the taxpayer desires to obtain administrative or litigation expenses. (This last point is discussed in more detail below.)

### **Administrative and Litigation Costs**

Prior to the enactment of TAMRA, taxpayers were able to obtain attorney’s fees only where the IRS lost *in court* and its position was not substantially justified. TAMRA adds Code section 7430, however, which provides that taxpayers may now also obtain fees expended where the case ends with an *administrative decision* in the taxpayer’s favor. To obtain these fees, the taxpayer must be the “prevailing party” and the IRS position must be substantially unjustified. However, the IRS decides who is the prevailing party and makes the call as to the propriety of its position. (Where the tax matter is in court, then the

This article was prepared at the request of the *Journal*. Ms. Stalzer practices with Zoe M. Hicks, P.C. Send reprint requests to Ms. Stalzer at 2296 Henderson Mill Rd., Ste. 110, Atlanta, GA 30345.

court will make the determination as to who is the prevailing party.) It will be interesting to see how often the IRS finds that its own position is "substantially unjustified," and how these determinations by the IRS fare on appeal to the Tax Court, should the taxpayer disagree with the IRS determination.

The types of costs which can be awarded under this new code section include the reasonable expenses of expert witnesses (however, not in excess of the highest rate of compensation for expert witnesses paid by the government); the reasonable cost of any study, analysis, engineering report, test, or project that is found to be necessary for the preparation of the prevailing party's case; and reasonable attorney's fees (although usually not more than \$75 per hour).

One further comment concerning the likely impact of this recent statutory change: It will not necessarily reduce the number of situations where the IRS makes adjustments or disallowances on the basis of a "weak" position, perhaps just to improve its bargaining position. The IRS position that must be "substantially unjustified" — and therefore support an award of cost to the taxpayer — is the one taken by the IRS in a statutory notice of deficiency or a final Appeals Division determination, both of which are the "end of the line" for a tax audit.

### Reliance on IRS Advice

All the misinformation transmitted via the IRS answer lines is not affected *at all* by the Taxpayer Bill of Rights. TAMRA adds new Code section 6404 (f), which refers only to reliance on *written* advice from the IRS. The IRS usually issues written advice

in Private Letter Rulings, based upon facts that are provided by the taxpayer. Thus, where taxpayers have requested written advice from the IRS and have provided accurate information, but have received inaccurate advice in response, then this new Code section provides relief from

***‘The IRS always has a fallback position in the collection area; it is in the driver’s seat in determining the reasonableness of its position; and the major problem of inaccurate telephone advice has not been addressed.’***

any *penalty* or *addition to tax* which results from this inaccurate advice. (Note there is no abatement in the *tax* itself.)

The taxpayer must *reasonably* rely upon the advice received from the IRS. Thus, where a taxpayer's situation is identical to one addressed in a previous IRS Private Letter Ruling, and where the taxpayer chooses to rely upon this prior Ruling, the taxpayer will not be able to use this new section to abate any penalty or addition to the tax which does result. This new Code section is specific to the taxpayer making the written request and to whom the IRS responds.

### Collection

The Taxpayer Bill of Rights does make some modifications regarding IRS collection procedures. Earlier IRS procedures provided that, when

the IRS took collection action via levy, the taxpayer received a notice of levy, giving the taxpayer *ten* days to pay the tax. Now, because of an amendment to Code section 3661, taxpayers have *thirty* days from the date of the notice of levy to pay the tax or take some other type of action which would delay collection by means of the levy. When the IRS levies on property, it receives the right to take the property in lieu of payment of taxes. The IRS can levy upon bank accounts, cars, homes, boats, or any other type of property which the taxpayer may have that could be sold by the IRS to pay the taxes.

This new extension of time does not, however, affect the jeopardy collection procedures already provided to the IRS, whereby the IRS may collect taxes by levy without providing notice if the IRS believes that the collection of taxes is in jeopardy (i.e., the taxpayer is going to remove the property from the country or destroy it or somehow make it unavailable to the IRS).

TAMRA also codifies the process whereby the IRS may enter into installment agreements with taxpayers for the payment of taxes. New Code section 6159 requires that the taxpayer provide accurate information of financial status to the IRS collection office and that both the IRS and the taxpayer must adhere to the agreement for its term. The IRS has been entering into installment agreements for years, albeit without specific statutory authority, and this does not appear to be a major change in IRS collection practices.

By amending Code section 6334, TAMRA does exempt the principal residence of a taxpayer from levy, *except* in the event that the Secretary of the Treasury finds



that the collection of taxes is in jeopardy, or the District Director or Assistant District Director of the Internal Revenue Service personally approves the levy on that property. This too is not much of a change from prior practice.

**‘At best, the practical positive effect from TAMRA may be to spur the IRS to be more circumspect in its positions and to listen more attentively to taxpayer complaints, now that Congress has taken note of some of the administrative problems.’**

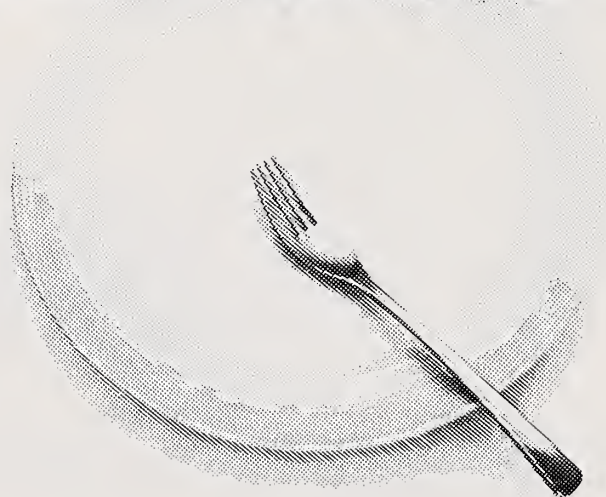
#### Conclusion

In conclusion, what began with a bang — and high hopes for significant benefits to taxpayers — appears to have ended with a whimper. The IRS always has a fallback position in the collection area; it is in the driver's seat in determining the reasonableness of its positions; and the major problem of inaccurate telephone advice has not been addressed. At best, the practical positive effect from the passage of TAMRA into law may be to spur the IRS to be more circumspect in its positions and to listen more attentively to taxpayers complaint, now that Congress has taken note of some of the administrative problems.

#### Notes

1. All references to the "Code" refer to the Internal Revenue Code of 1986, as amended by the Technical and Miscellaneous Revenue Act of 1988.

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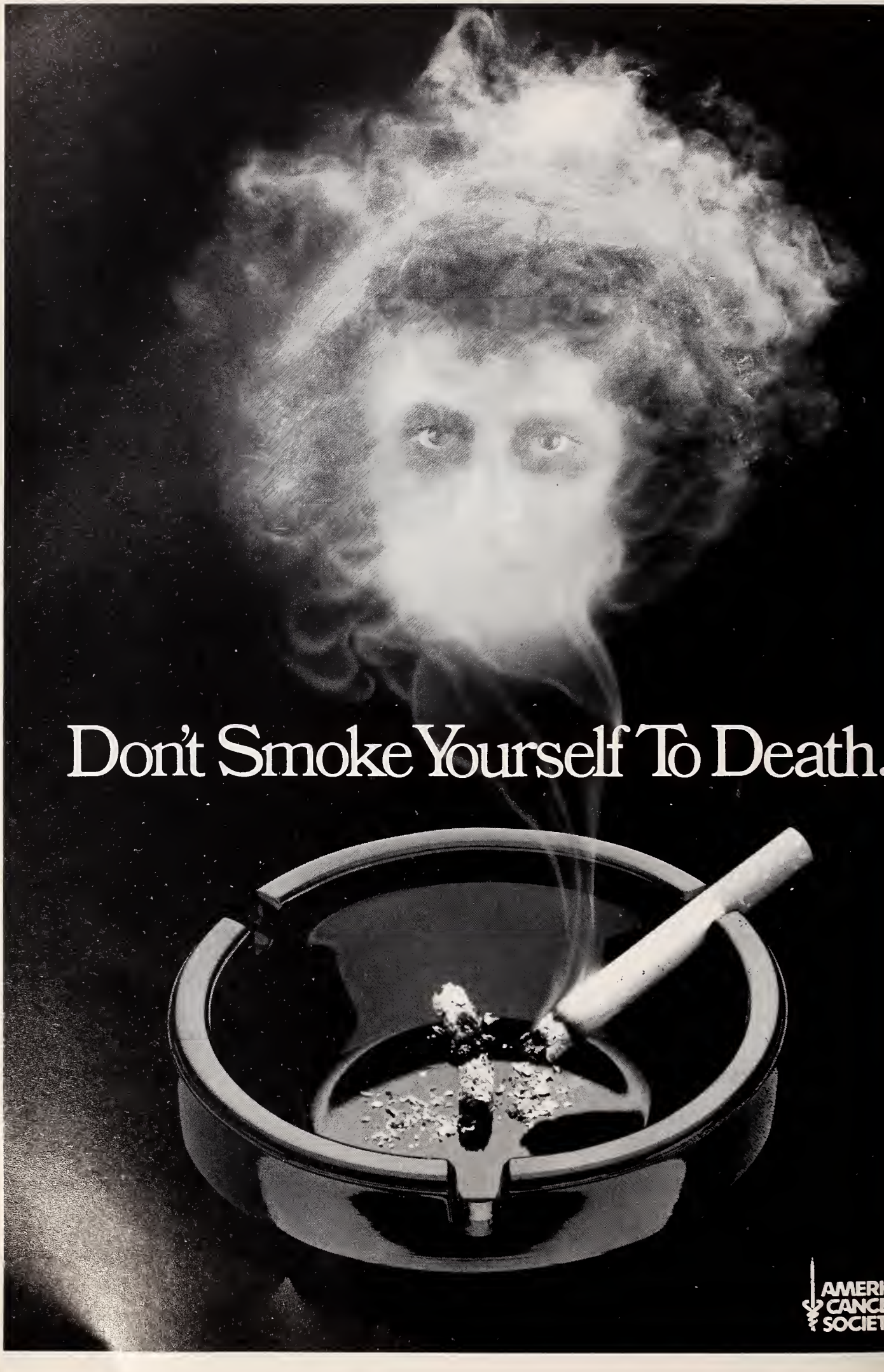


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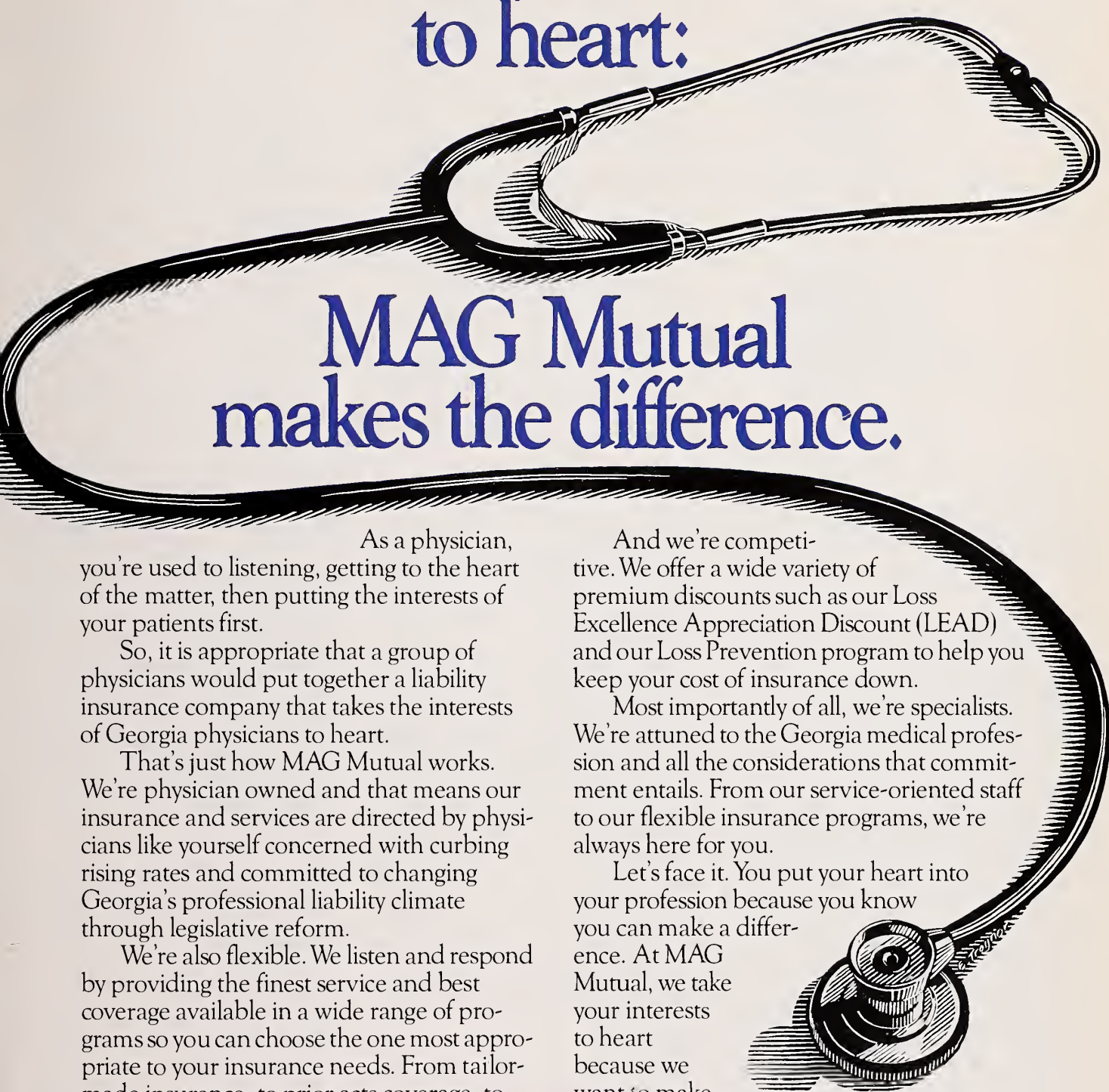




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Sorter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;294:687-90.

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# VASOTEC®

## (ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

**Contraindications:** VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

**Warnings:** *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

**Hypotension:** Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. Excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Precautions:** *General:* Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Osmotic reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

**Evaluation of patients with hypertension or heart failure should always include assessment of renal function.** (See DOSAGE AND ADMINISTRATION.)

**Hyperkalemia:** Elevated serum potassium ( $> 5.7$  mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

**Information for Patients:**

**Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

**Drug Interactions:**

**Hypotension:** *Patients on Diuretic Therapy:* Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

**Agents Causing Renin Release:** The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

**Lithium:** A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

**Pregnancy—Category C:** There was no teratogenicity or fetotoxicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

**Nursing Mothers:** Milk in lactating rats contains radioactivity following administration of  $^{14}$ C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Adverse Reactions:** VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

**HYPERTENSION:** The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

**HEART FAILURE:** The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

**Cardiovascular:** Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

**Digestive:** Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

**Nervous/Psychiatric:** Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

**Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

**Respiratory:** Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

**Skin:** Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

**Other:** Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

**Angioedema:** Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

**Clinical Laboratory Test Findings:**

**Serum Electrolytes:** Hyperkalemia (see PRECAUTIONS), hyponatremia.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

**Other (Causal Relationship Unknown):** In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

**Liver Function Tests:** Elevations of liver enzymes and/or serum bilirubin have occurred.

**Dosage and Administration:** **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

**Dosage Adjustment in Hypertensive Patients with Renal Impairment:** The usual dose of enalapril is recommended for patients with a creatinine clearance  $> 30$  mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance  $\leq 30$  mL/min (serum creatinine  $\geq 3$  mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

**Heart Failure:** VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

**Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia:** In heart failure patients with hyponatremia (serum sodium  $< 130$  mEq/L) or with serum creatinine  $> 1.6$  mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486.

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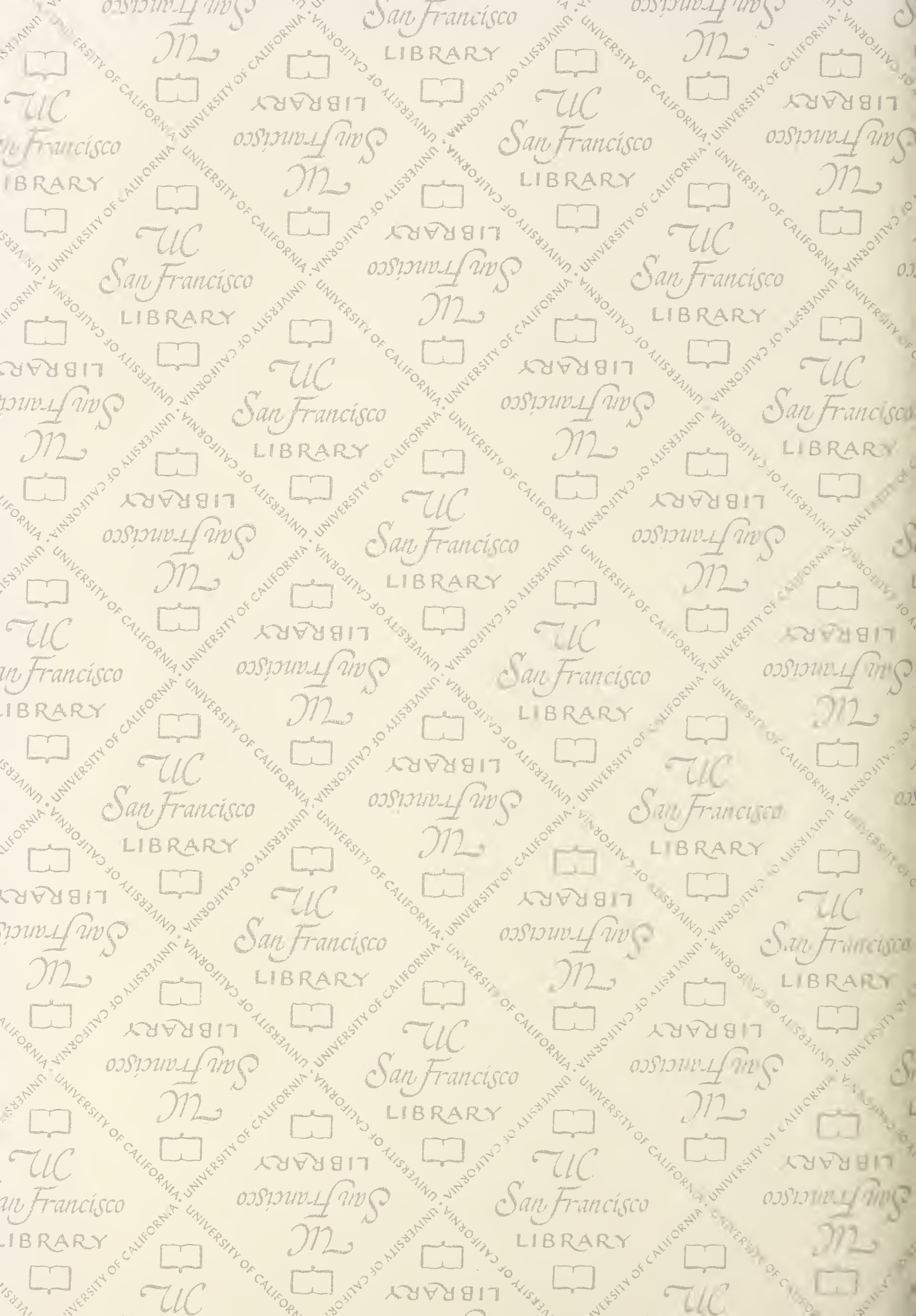














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